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State plan for developmental disabilities



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STATE OF MONTANA  
STATE PLAN FOR DEVELOPMENTAL DISABILITIES SERVICES  
FISCAL YEARS 1981-1983

A.A. Zody, Chairman,  
Developmental Disabilities Planning & Advisory Council

Beth Richter, Executive Director

Michael Dalin, Consultant on State Plan

Pam Pouliot, Secretary



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DEVELOPMENTAL DISABILITIES  
STATE PLAN

FISCAL YEARS 1981-1983

STATE OF MONTANA

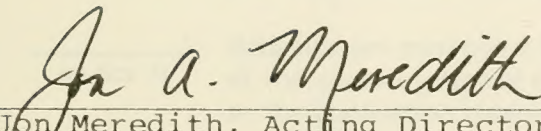
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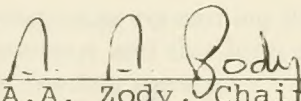
The Montana State Developmental Disabilities Planning and  
Advisory Council

Submitted to:

U.S. Department of Health and Human Services, Office of  
Human Development Services, Developmental Disabilities  
Administration, Region VIII Office

This State Plan is a joint endeavor of the State Planning  
Council and the State Administering Agency for Developmental  
Disabilities.

  
Jon Meredith, Acting Director  
Department of Social and  
Rehabilitation Services

  
A.A. Zody, Chairman  
Developmental Disabilities  
Planning & Advisory Council







## Office of the Governor

Thomas L. Judge  
GovernorGeorge L. Bousliman  
Director

## Budget and Program Planning

Capitol Building - Helena, Montana 59601

## PROJECT NOTIFICATION AND REVIEW SIGNOFF

State Application

Identifier (SAI) Number 80-07-47Date July 30, 1980PROJECT TITLE: State Plan for Developmental Disabilities Services 1981-1983APPLICANT AGENCY: Montana Department of Social and Rehabilitation Services  
Developmental Disabilities Planning & Advisory CouncilAGENCY ADDRESS: 1218 E. Sixth Ave., Helena, Mt 59601FEDERAL PROGRAM TITLE, AGENCY, & CATALOG NUMBER: P.L. 95.602Social Security ActAMOUNT OF FEDERAL FUNDS REQUESTED: N/APROJECT DESCRIPTION: Montana state plan for developmental disabilities services for  
1981-1983.CONTACT PERSON: Beth Richter, Executive Director PHONE: (406)449-3878

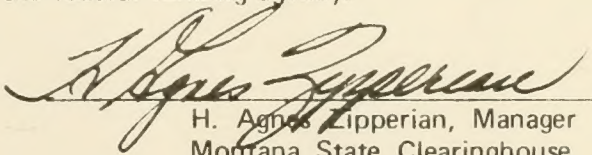
The State Clearinghouse makes the following disposition concerning the above:

X  
(BLOCK 1)

No unresolved problems were identified by the State Clearinghouse in the review process of the above captioned project. This form must be attached to the application submitted to the federal funding agency.

(BLOCK 2)

Attached are comments by the State Clearinghouse concerning the review process of the above captioned project. These comments and this form must be attached to the application submitted to the federal funding agency.

  
H. Agnes Zipperian, Manager  
Montana State Clearinghouse

PLEASE RETURN THIS PORTION OF FORM TO:

SAI No. 80-07-47Montana State Clearinghouse  
Office of Budget and Program Planning  
Capitol Annex  
Helena, Montana 59601APPLICATION OFFICIALLY SUBMITTED TO \_\_\_\_\_ ON \_\_\_\_\_  
(Federal Agency) (Date)SUBMITTED BY \_\_\_\_\_  
(Agency) iv (Signature)

(Please inform this office of application approval or denial by the funding agency.)





STATEMENT BY STATE ATTORNEY GENERAL

With reference to the Montana State Plan for Developmental Disabilities Services submitted under the provisions of the developmental disabilities program, as amended by P.L. 95-602, to my knowledge and belief: Nothing in this 1981-1983 State Plan is inconsistent with State law.

NAME: MIKE GREELY, STATE ATTORNEY GENERAL

SIGNATURE: 

DATE: 9/29/80





## INTRODUCTION

Contained herein is the 1981-1983 Montana State Plan for Developmental Disabilities Services. Although revisions to some portions of the plan (budget, goals and objectives, etc.) will be developed for Fiscal Years 1982 and 1983, the majority of the plan will remain essentially unchanged for the three year period.

It is hoped that, by 1983, more information will be available about persons who fit under the definition of "developmental disability" as contained in Public Law 95-602. As will be seen, persons who would be considered developmentally disabled under that law are, for the most part, indistinguishable from all other clients served by the agencies whose programs are detailed in this plan. It would be of great benefit to planners and others, to be able to identify the developmentally disabled among those groups of persons served by these programs.

Following is a description of the contents of the State Plan:

- Section 1 contains a description of the membership and activities of the State Council, the Council's relationship to SRS, and SRS' role in connection with DD programs.
- Section 2 contains a description of the characteristics of the DD population in Montana (according to the new definition in the federal law) and estimates of the number of DD persons in Montana.
- Section 3 contains a description of services available to the DD population as well as the number of DD persons being served by each of the following programs:
- Aging Services
  - Boulder River School & Hospital
  - Corrections (DD Offenders)
  - Deaf/Blind Programs
  - Developmental Disabilities Division
  - Diagnosis & Evaluation Programs
  - Eastmont Training Center
  - Health Systems Agency
  - Maternal & Child Health/Handicapped Children's Services
  - Mental Health
  - Public Assistance/Medical Assistance
  - Regional DD Councils
  - Rehabilitative Services (Vocational Rehabilitation)
  - School for the Deaf and Blind
  - Social Services
  - Special Education
  - Visual Services
  - Warm Springs State Hospital



- Section 4 contains a description of gaps and barriers to services, the strengths and weaknesses of the programs listed above, and estimates of services needed by the developmentally disabled in the state.
- Section 5 contains State Council goals and objectives for the next federal fiscal year and a budget for expenditure of the Council's federal formula grant.
- Section 6 identifies standards and/or certification procedures which apply to personnel who work in DD programs, lists training programs available to those personnel, and contains the State's assurance that it will comply with the federally-required Evaluation System Plan (applying only to expenditure of P.L. 95-602 funds).
- Section 7 contains information about what the State Council and/or the state agencies intend to do to provide special assistance to poverty areas and minority groups, to maximize the use of volunteers, and to inform the public of the kinds and locations of services available.
- Section 8 contains a listing of assurances which commit the state to compliance with specific provisions of P.L. 95-602 (submitting required reports, assuring architectural accessibility in programs assisted with P.L. 95-602 funds, assuring the utilization and maintenance of IHPs, etc.).

SECTION 1

STATE COUNCIL AND ADMINISTERING AGENCY





## STATE PLANNING COUNCIL

### Establishment of Council

The Montana State Developmental Disabilities Planning and Advisory Council was originally established in 1971 by Gubernatorial Executive Order under the mandate of Public Law 91-517. In 1974, the Council was given state statutory authority (2-15-2204, M.C.A. 1979), and during the same legislative session, a law establishing five substate regional developmental disabilities advisory councils (53-20-207) was enacted.

The state law establishes the membership of the Council at a maximum of 22 members, all of whom shall be appointed by the Governor, and provides that those members shall be:

- the director of the State Department of Social and Rehabilitation Services (SRS) or a designee
- the director of the State Department of Institutions or a designee
- the director of the State Department of Health and Environmental Sciences (SDHES) or a designee
- the Superintendent of Public Instruction or a designee
- two members of the State Senate
- two members of the State House of Representatives
- four consumers or consumer representatives, at large
- one member each of the five regional DD councils, who must also be consumers or consumer representatives
- one member each of the following professional disciplines: medicine, law, psychology, social work and special education.

The directors of SRS and of the Department of Institutions both serve personally on the Council. The director of SDHES and the Superintendent of Public Instruction have designated a representative of the Maternal and Child Health Bureau and the Director of the Special Education Unit, respectively, to represent them on the Council.

The Council currently has five vacancies under state law, as follows: the legal, social work and special education representatives, one State Senator, and one member of the State House of Representatives.



In a 1977 amendment to the state law, terms of the members were changed from one-year appointments to a rotation procedure, as follows:

- the state agency directors (or designees) serve until the term of the directorship expires
- state legislators serve one-year terms from July 1 through the following June
- eight of the other members of the Council (selected randomly) serve three and one-half year terms
- the remaining six members (also selected randomly) serve terms of five and one-half years.

### Council Duties and Responsibilities

Federal law(Public Law 95-602) requires that the Council:

- develop jointly with the state agency or agencies the State DD Plan
- monitor, review and evaluate the implementation of the State Plan
- to the maximum extent feasible, review and comment on all state plans which relate to programs affecting persons with developmental disabilities
- submit such reports on Council activities as the Department of Health and Human Services may request and keep records to verify the activities described in those reports.

Additionally, state law (53-20-206) charges the Council with the following duties:

- advise SRS, other state agencies, councils, local government and private organizations on programs for services to the developmentally disabled
- develop a plan for a statewide system of community-based services for the developmentally disabled
- serve in any capacity required by federal law for the administration of federal programs for services to the developmentally disabled.

To clarify these responsibilities, the Council recently developed the following "Policy Statement" concerning its role and responsibilities:

"We, the members of the Montana Developmental Disabilities Planning and Advisory Council, in recognition of our obligations and responsibilities to the people of Montana, and to those citizens who are developmentally disabled, and having taken cognizance of changing societal conditions, do hereby declare and affirm this statement of policy and purpose, as follows:

The Council shall continue to comply with the requirements of Federal and State Law and regulations, and with those additional duties as prescribed by the Governor of Montana and as determined by the Council.

The Council shall strengthen its advisory function by remaining vigilant to the needs of developmentally disabled persons. The Council will also be vigilant to assure that those needs are being met by efforts in the public and private sectors, and to the national and international trends which will facilitate these efforts. The Council shall actively provide reasoned, current and competent advice on these issues.

The Council shall continue to participate in planning activities and in the creation and formulation of the State Developmental Disabilities Annual Plan, and the Council shall emphasize the accuracy, appropriateness, realism and usefulness of the plan. The Council shall also review and comment on other plans which have implications for developmental disabilities.

The Council shall act as coordinator and catalyst in the provision of services by various public and private agencies, to the end that services will be complete as possible and as unduplicated as possible.

The Council shall solicit applications from and award grants to those agencies and persons who propose to perform high impact activity with potential for statewide significance and replication, including research, investigation, analysis, demonstration and validation, and to other agencies and persons only when residual funds are available.

The Council shall encourage the strong and active advocacy of the legal and societal rights of developmentally disabled persons, including, but not limited to, the rights to educational, residential, employment and vocational, transportation and community activities and services.



The Council shall exert its active influence in the interests of perfecting, extending, changing and completing the network of services and programs provided to the developmentally disabled citizens of Montana by public and private agencies and organizations.

The Council shall promote an adequate system to monitor developmental disabilities programs and services through a process of proposing, modeling, demonstrating, starting, encouraging and evaluating monitoring efforts on system-wide and individual bases, and by performing appropriate self-evaluation.

The Council shall continually review its working relationship with other public and private agencies, and shall adjust to the demands and opportunities of changing circumstances and conditions.

The members of the Council shall always be aware that their individual and collective efforts must be directed to the benefit of those Montanans who are developmentally disabled.

ADOPTED, January 24, 1980"

#### Council Membership

See Table 1.1.

TABLE 1.1

## MEMBERSHIP OF THE STATE PLANNING COUNCIL

Representatives of Federally Assisted Programs	Representative	Position in State Agency	Name of State Agency	Term of Appointment
Developmental Disabilities	Jon Meredith	Director	SRS	Term of Office
Education for the Handicapped	Shirley Miller	Director, Special Education Unit	Office of Public Instruction	Term of Superintendent of Public Instruction.
Vocational and other Rehabilitation Programs	Jon Meredith	Director	SRS	Term of Office
Public Assistance	Jon Meredith	Director	SRS	Term of Office
Medical Assistance	Jon Meredith	Director	SRS	Term of Office
Social Services	Jon Meredith	Director	SRS	Term of Office
Maternal & Child Health	Joyce DeCunzo	SSI-DCP Coordinator, Maternal & Child Health Bureau	SDHES	Term of Office of Director of SDHES
Crippled Children Svcs.	Joyce DeCunzo	Same as above	SDHES	Same as above
Mental Health Services	Larry Zanto	Director	Department of Institutions	Term of Office



TABLE 1.1 (Cont'd)

Other required Representation	Representative	Title	Organization	Term of Appointment
Higher Education	Robert Crow	Director	Montana University Affiliated DD Program	7/1/83
Local Governmental Agencies	Esther Bengtson	Teacher	Shepherd School District	6/30/81
	Dick Carlson	School Ad- ministrator	Butte School District	7/1/81
Non-Governmental Agencies	A.A. Zedy	Member	Eastern Mt. Mental Health Center Board	7/1/81
	Gary Marbut	Member	American Association on Mental Deficiency	7/1/81
	Florence Lucas	President	MT Association for Retarded Citizens	7/1/81
	Joey Lillemon	Member	UCP of Montana	7/1/83
	H.P. Brown	Member	UCP of Montana	7/1/81
Persons with Developmental Disabilities:	Douglas Schram	----	----	7/1/83
	H.P. Brown	----	----	7/1/81

TABLE 1.1 (Cont'd)

Consumers and Their Representatives	Address	Relationship to Individual	Term of Appointment From To
Persons Representing Individuals with Mental Impairing Conditions:			
Dick Carlson	3445 Parkway Butte 59701	Father	7/1/77 7/1/81
Joey Lillemon	900 4th Avenue NW Great Falls 59404	Mother	7/1/77 7/1/83
Florence Lucas	1443 Jackson Street Missoula 59801	Mother	7/1/77 7/1/81
Gary Marbut	310 D Western Bank Bldg. Missoula 59801	Father	7/1/77 7/1/81
Jill Rohyans	801 Maynard Road Helena 59601	Mother/Sister	7/1/77 7/1/83
Sam Stewart	1720 Iris Lane Billings 59102	Father	7/1/77 7/1/81
Lee Warren	Box 226, Nashua 59428	Father	7/1/77 7/1/81
A.A. Zody	503 South Pearson Glendive 59330	Father	7/1/77 7/1/81

TABLE 1.1 (Cont'd)

Appointments Under State Law	Name	Address	Term of Appointment	
			From	To
Consumer at Large	A.A. Zody (Chairman)	503 South Pearson Glendive 59330	7/1/77	7/1/81
Representative/Medicine	Allen Hartman, M.D. (Vice-Chairman)	Box 2555 Billings 59101	7/1/77	7/1/83
State House of Representatives	Esther Benetson	Shepherd 59079	7/1/79	6/30/80
Representative/Region II	H.P. Brown	2733 Fern Drive Great Falls 59404	7/1/77	7/1/81
Representative/Region IV	Dick Carlson	3445 Parkway Butte 59701	7/1/77	7/1/81
Department, Social and Rehabilitation Services	Jon Meredith	111 Sanders Helena 59601	7/1/77	Term of Office
Department/Health and Environmental Sciences	Joyce DeCunzo	25 South Ewing Helena 59601	7/1/77	Term of Office of Director
Consumer at Large	Joey Lillemon	900 4th Avenue NW Great Falls 59404	7/1/77	7/1/83
Representative/Region V	Florence Lucas	1443 Jackson Street Missoula 59801	7/1/77	7/1/81
Consumer at Large	Gary Marbut	310D Western Bank Bldg. Missoula 59801	7/1/77	7/1/81



TABLE 1.1 (Cont'd)

Appointments Under State Law (Cont'd)	Name	Address	Term of Appointment	
			From	To
Office of Public Instruction	Shirley Miller	455 South Park Helena 59601	7/1/77	Term of Office of Superintendent
State Senate	Stuart Olson, M.D.	Box 928 Glendive 59330	7/1/79	6/30/80
Consumer at Large	Jill Rohyans	801 Maynard Road Helena 59601	7/1/77	7/1/83
Representative/Region III	Sam Stewart	1720 Iris Lane Billings 59102	7/1/77	7/1/81
Representative/Region I	Lee Warren	Box 226 Nashua 59248	7/1/77	7/1/81
Department of Institutions	Larry Zanto	1539 11th Avenue Helena 59601	7/1/77	Term of Office
Representative/Psychology	Robert Crow	MT. University Affiliated Program Satellite U. of Montana Missoula 59801	7/1/77	7/1/83
Representative/Special Educ	Douglas Schram	59 Wilkinson Lane Great Falls 59404	7/1/77	7/1/83
Representative, Law	<u>VACANCY</u>			
Representative, Social Work	<u>VACANCY</u>			
State Senator	<u>VACANCY</u>			
Member, House of Representatives	<u>VACANCY</u>			



## Council Staff

State law authorizes the Council to "employ and fix the compensation and duties of necessary staff", thus staff are hired and supervised by the Council. Council bylaws provide that the Executive Director shall be supervised by the Council chairman and other staff shall be supervised by the Executive Director. Salaries and grade levels for positions of Council staff are established according to the Statewide Personnel Classification and Pay Plan. The Montana Legislature has authorized three fulltime positions for the Council, which are currently held by the following individuals:

Executive Director:	Beth Richter
Planner:	Nina Vaznelis
Secretary:	Pam Pouliot

## State Administering Agency

The State Administering Agency is the State Department of Social and Rehabilitation Services, whose address is 111 Sanders Street (P.O. Box 4210), Helena, Montana 59601. The person who is responsible for the actions of the agency is Jon Meredith, Director.

The functions and responsibilities of the Department of Social and Rehabilitation Services, as they relate to services for developmentally disabled persons, include administration of the following programs:

- developmental disabilities
- public assistance
- medical assistance
- social services
- vocational rehabilitation
- aging services
- visual services
- children and youth services.

Within SRS, the Developmental Disabilities Division (DDD) is primarily responsible for the statewide community-based developmental disabilities program. This program is a system of services which utilizes contracts with and grants to local non-profit corporations to provide services to developmentally disabled persons and their families. Under state law, these services may include the following:



- evaluation services
- diagnostic services
- treatment services
- day care services
- training services
- education services
- employment services
- recreation services
- personal care services
- domiciliary care services
- special living arrangements services
- counseling services
- information and referral services
- follow-along services
- protective and other social and sociolegal services
- transportation services.

In addition, the DDD coordinates programs with other agencies for maximum and efficient provision of services.

#### Relationship Between Council and Administering Agency

The Council is allocated under state law to SRS for administrative purposes only. Under this provision (2-15-121), SRS shall:

1. direct and supervise the budgeting, record-keeping, reporting and related administrative and clerical functions of the Council
2. include the Council's budgetary requests in the departmental budget
3. collect all revenues for the Council and deposit them in the proper fund or account
4. print and disseminate for the Council any required notices, rules or orders adopted, amended or repealed by the Council.

Departmental procedures have been developed by SRS to fulfill these functions with various appropriate divisions within the agency assigned specific tasks.

## Fiscal Control

Funds allocated under P.L. 95-602 are granted to the State of Montana through the Council. These funds, plus any state matching funds, become a part of the Council's budget, which is a budget within SRS separate from all other SRS funds. All funds are received, disseminated and accounted for pursuant to the requirements of the Statewide Budgeting and Accounting System.

## Administration of the State Plan

Procedures for administration of all developmental disabilities services and programs in Montana are mandated by provisions within state laws and administrative rules. The State Plan is implemented primarily by the following agencies, which are all represented on the Council:

- the Department of Social and Rehabilitation Services (SRS)
- the Department of Health and Environmental Sciences (SDHES)
- the Department of Institutions
- the Office of Public Instruction (OPI)

One other agency, the State School for the Deaf and Blind, is administered by the State Board of Public Education, which, at the present time, is not represented on the Council.

The functions of SRS are indicated on page 10.

The SDHES has within its department the Bureau of Maternal and Child Health, which administers such programs as handicapped children's services, crippled children services, and early and periodic screening and diagnosis. Program responsibility for the following programs also rests within the SDHES: health planning and resource development; and preventive health services.

The Department of Institutions administers all state custodial and correctional institutions serving, among others, the following persons who are included within the activities covered in the State Plan:

- the mentally retarded
- the mentally ill
- the aged
- emotionally disturbed children

In addition, the Department of Institutions administers funds allocated for community mental health services throughout the state.

The Special Education Unit of the Office of Public Instruction is responsible for state-level administration of special education programs throughout the state, including the federal Education of All Handicapped Act.

### Council Grants Procedure

The Council sets aside a portion of its funds each year for grants to public and non-profit agencies. As indicated in the Council's Policy Statement, the purpose of the grants program is, primarily, to award funds to agencies and persons who propose to perform high impact activities which have potential for statewide significance and replication, including activities relating to research, analysis and demonstration, and secondarily, to award funds to other agencies and persons for service types of activities.

As can be seen by Table 1.2, the Council has a three-level application process for granting of its funds. The first is a brief, two-page "Grant Intent Statement" (GIS), which is reviewed and either approved, disapproved or re-referred to the applicant for further clarification by the Council's grants review committee. If the GIS is approved, a Grant Application is invited. If the GIS is disapproved, the procedure ends at this point, but is subject to review by the full Council. If a Grant Application is submitted, the same committee reviews this and makes a recommendation for approval or disapproval to the full Council.

Occasionally, a Request for Proposal (RFP) will be issued by the Council for a specific study or project the Council wishes to sponsor. A procedure similar to the one described above is utilized when an RFP results in one or more proposals for the same project.

The contents of the Council's Grant Application are as follows:

- identification of applicant organization
- abstract of proposal
- proposed budget
- biographical sketch of professional staff involved in project
- presentation of project plan
- goals and objectives of project
- notification of assurances relating to compliance with state and federal laws.

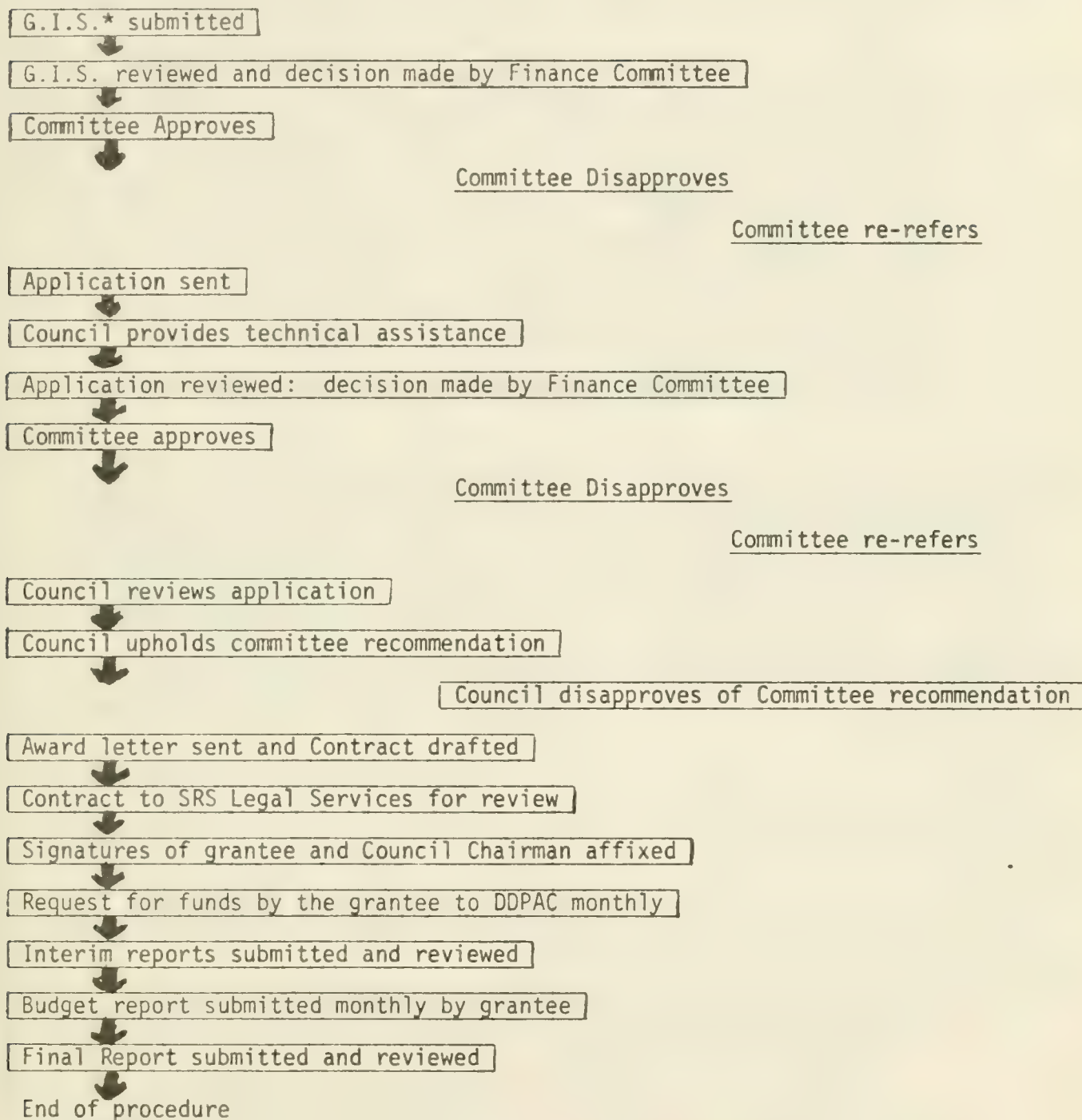
The Council's Grant Award Agreement, or contract, contains the following provisions:

- purpose of the grant
- duration of the project



TABLE 1.2

Flow Chart for Council-Funded Grants



\*Grant Intent Statement

- services to be provided
- client eligibility (compliance with P.L. 95-602)
- grant payment provisions and matching funds verification
- details of grant budget and conditions on altering the budget
- requirements for interim and final reports on project
- fiscal controls on grant monies
- restrictions on purchase of equipment
- Council access to grantee's premises
- return of unexpended funds
- copyright restrictions
- insurance coverage
- civil rights compliance
- confidentiality procedures
- client grievance procedures
- compliance with federal laws (including P.L. 95-602)
- eventualities in connection with noncompliance with contract provisions
- other standard contract provisions required by state law.

Projects funded with the Council's grant monies are evaluated in two different ways: 1) written monthly budget reports, quarterly progress reports and a final report on achievements or outcomes are required as a condition of Council funding; and 2) during the course of the grant, the project is evaluated by means of an on-site visit by an individual Council member who provides a written report on his or her evaluation to the full Council. Additionally, all Council grantees will, after October 1, 1982, be subject to review by way of the Council's Evaluation System which is currently being developed pursuant to P.L. 95-602.

### State Planning Process

Two major meetings relating to development of the 1981-1983 State Plan were held in early 1980:

1. In January, a meeting was held between the State Council's Executive Committee and regional council representatives and the five regional council chairpersons. The state plan development process was discussed. Agreements were made concerning submission to the State Council by regional councils the current regional plans for services. Timelines were established and a major portion of the meeting was devoted

to a discussion of methods of improving the planning process in the future in order to make the state plan a viable and useful document containing all available information about service needs of developmentally disabled persons in the state.

2. In February, a meeting was held between the Council's Planning Committee and representatives of 17 state programs (including the 11 federally-mandated state programs) which provide or have the potential for providing services to developmentally disabled persons. The purpose of the meeting was to discuss the new federal definition of "developmental disability" and the manner in which it has expanded the Council's planning role; the new requirements in terms of state plan development; the "priority service areas" and how they will affect plan development; and designation of a liaison from each of these programs to work with the Council staff in data gathering and plan development.

Individual Council members volunteered to assist with data collection. A data survey instrument was developed by staff and utilized by Council members who gathered the necessary data by interviewing appropriate agency staff members. Some follow-up interviews or phone calls by staff were necessary to either expand or clarify the data collected by Council members.

The Council hired a temporary staff person specifically to compile and analyze the data collected by Council members and to develop a draft plan for the Council.

Prior to commencement of the activities described above, the Council funded a special study and analysis of the meaning and impact on Montana of the new federal definition of "developmental disability". The interim results of this study are being utilized in identifying developmentally disabled persons in Montana, locating services available to those persons, identifying agencies which provide those services, and estimating the total number of developmentally disabled persons in the state.

The plan will be available for "A-95" review for a 45-day period prior to its submission to the federal government.

#### Evaluation of Plan by Council

As in the past, the Council will continue to utilize "Program Performance Reports" (PPR) to report on achievement or progress toward achievement of objectives in the State Plan. A PPR for each objective is completed by a representative of the agency to which the objective is assigned for implementation.



After the agency portion of the report has been completed, members of the Council's Evaluation Committee add comments on the content of the report on behalf of the Council. PPRs are completed and submitted to the federal government on a quarterly basis throughout the plan year.

Dependent upon the content of the completed reports, the Evaluation and/or Planning Committees of the Council will sometimes recommend to the full Council that a particular objective be deleted on the basis that it cannot or will not be achieved, partially or completely, during the plan year. Another recommendation has been that, in the absence of agency achievement or progress toward achievement of a particular objective, the Council undertake a project or study itself or grant funds to have the objective accomplished by some other individual or organization.

### Evaluation of Council Activities

For the past two years, the Council has conducted a "self-evaluation survey", a self-examination and measuring of satisfaction with Council direction, activities and effectiveness by Council members themselves. The results of the 1979 self-evaluation survey led to a Council "retreat" in November, at which the Council's past, present and desired future roles were discussed at length. The Council Policy Statement, replicated earlier in this Section, resulted from the concepts which were developed at the retreat and from subsequent Council discussions.

In addition to the Policy Statement, other activities which have occurred and will occur as a result of the Council retreat are:

- restructuring of the Council's committees and development of more pertinent work plans for the committees
- creation of a Special Committee on Council Composition to study the possibility of restructuring the Council itself
- development of a "priority system" for determining which tasks the Council should undertake in the future.

### Council Accomplishments

Table 1.3 contains a list of all projects, programs and studies funded by P.L. 95-602 funds during federal fiscal year 1979. Priority service areas have been selected by the Montana Council for FFY 1981, but none was selected for earlier years.

TABLE 1.3

PUBLIC LAW 95-602 FUNDED GRANTS  
FOR FEDERAL FISCAL YEAR 1979

GRANTEE	AMOUNT	PURPOSE	NUMBER OF DD PERSONS SERVED
Glen-Wood, Inc., Plentywood	\$ 2,500	To purchase furnishings and equipment for new semi-independent living facility	3
Missoula DD Community Homes Council	2,676	To purchase furnishings for new community group home facility	7
New Hope, Inc., Butte	5,273	To purchase furnishing for new semi-independent living facility	8
St. Vincents Hospital, Billings	1,425	To purchase air transport respirator for newborn intensive care nursery	24/year (Est)
Missoula Community Hospital	3,375	To purchase infant scale and respirator for newborn intensive care nursery	Western Montana
Developmental Disabilities/Montana Advocacy Program	15,000	To provide statewide protection and advocacy services	Statewide
Flathead Transportation, Inc. Kalispell	4,975	To provide rural transportation services for clients of day activities center	12
Professional Planning and Research Consultants, Helena	4,000	For development of a state DD Prevention Plan	Statewide
UCP of Montana	2,100	To purchase puppets to be utilized in teaching non-handicapped children about handicapped children	Statewide
Missoula Advocacy Program	7,600	To train DD adults in "self" advocacy	25

TABLE 1.3 (Cont.)

GRANTEE	AMOUNT	PURPOSE	NUMBER OF DD PERSONS SERVED
West-Mont Community Care, Helena	\$ 6,845	To study the feasibility of development of a 15-bed or less ICF/MR for the Helena area.	7
Yellowstone County ARC, Billings	2,579	To conduct a training workshop on autism for parents and professionals	Statewide
Professional Planning and Research Consultants, Helena	6,261	To assess the meaning of and impact for Montana of the new federal definition of "developmental disability".	Statewide
STEP, Inc., Billings	29,978	To provide care and training in a new children's community group home.	4
Region II Child & Family Services, Great Falls	19,328	To provide care and training in a new com- munity group home for adolescents	5
Region II, Child & Family Services	50,695	To provide care and training in the children's community group homes.	15
	<hr/> \$164,610		



## SECTION 2

ESTIMATES OF THE DD POPULATION



## THE DEVELOPMENTALLY DISABLED POPULATION

### A New Clientele

The definition of developmental disabilities, as contained in Public Law 95-602, the "Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978", is defined as:

"...a severe, chronic disability of a person which--

- (1) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (2) is manifested before the person attains age twenty-two;
- (3) is likely to continue indefinitely;
- (4) results in substantial functional limitation in three or more of the following areas of major life activity:
  - (a) self-care;
  - (b) receptive and expressive language;
  - (c) learning;
  - (d) mobility;
  - (e) self-direction;
  - (f) capacity for independent living; and
  - (g) economic self-sufficiency; and
- (5) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are individually planned and coordinated."

It is particularly important to discuss the new federal definition of "developmental disability" within the first few pages of this plan, since the definition quoted above varies from the state definition of DD, which is very similar to the definition contained in the federal law subsequent to the enactment of P.L. 95-602 in November of 1978. The state (and, substantially, the former federal) definition is as follows:

"'Developmental disabilities' means disabilities attributable to mental retardation, cerebral palsy, epilepsy, autism, or any other neurological handicapping condition closely related to mental retardation and requiring treatment similar to that required by mentally retarded individuals if the disability originated before the person attained age 18, has continued or can be expected to continue indefinitely, and constitutes a substantial handicap of the person." (53-20-202, M.C.A. 1979)

As can be seen by contrasting the two definitions, the new federal definition is based solely on an individual's functional limitations, rather than the diagnosis or nature of his disabling condition. On the other hand, the state definition applies the term "developmental disabilities" generally to persons who suffer from one of the four handicapping conditions listed: mental retardation, cerebral palsy, epilepsy or autism.

The DD definition in state law is not only applicable to the planning activities of Montana's State Council and the five regional DD advisory councils, but more importantly, provides the mandate for the State Department of Social and Rehabilitation Services concerning the target population the department is expected to serve in the statewide community-based DD system.

However, the reader of this Plan should be cautioned that when the term "developmental disability" is used throughout the Plan, it generally refers to all substantially handicapped persons who fit within the new federal definition of developmental disability; when the phrase "statewide community-based DD system" is used, it refers to services available to persons who fit within the state definition of developmental disability, i.e., persons who are mentally retarded, cerebral palsied, epileptic or autistic.

The definition of DD, as stated in P.L. 95-602, provides only broad considerations for determining who is included in the population. The state's need to "operationalize" the definition is therefore clear, since it has implications for a) the functioning and structuring of the State DD Council; b) estimating the size and nature of the DD population in the state; c) developing and applying future population projections; d) making the definition understandable to potential clients and their families; and e) determining appropriate usages of the funds allocated to the State Council under P.L. 95-602.

#### The New Definition: A Non-Categorical Approach

A recent national study addresses several implications of the revised DD definition. Included are suggested answers to two pertinent questions: What is the concept of a developmental disability which underlies the modified definition? What is the definition trying to say?

- a) The new definition reads: "a developmental disability is a severe, chronic set of functional limitations which result from any physical and/or mental impairment and which manifests itself before age 22".
- b) Important to the definition is the concept of pervasiveness: the impact of the disability on the afflicted person's life and the resultant need for services to help alleviate the effects of such an impact.



- c) The specific elements of the new legal definition are perhaps best regarded as individual criteria, each of which must be present for a person to be considered developmentally disabled.
- d) Since the impact of a developmental disability on a person's life (and the resultant need for services) derives from the cumulative effect of all the criteria, the definition is worded specifically counter to the concept of having alternative criteria where, for example, a person would be developmentally disabled if some combination of the criteria, but not all, were met.
- e) The concept of the manifestation of the disability during developmental years (before age 22) is clearly distinguishable from one which requires merely that the condition "originates before the person attains age 18" (P.L. 94-103, the former federal law, and also contained in the state law). The age difference between 18 and 22 is not the issue. Rather, the emphasis is on the comparison between manifestation and origin. Therefore, whatever the nature of their origin, so long as the effects of the disability are measurable before age 22, this specific condition is met. Consequently, a developmental disability is distinguishable from other substantial chronic disabilities by the fact that it occurs early enough in a person's life to interfere with that person's acquisition of certain basic skills.
- f) Finally, a developmental disability is so pervasive in its effect, because of its cumulative impact and early onset, that the person so afflicted is likely to require long-term care through life. Specifically, the kinds of care needed (see definition, page 20, item 5) are intrinsic to the definition under P.L. 95-602, while not even mentioned in the earlier P.L. 94-103. Thus, to be a developmentally disabled individual, one must be severely and chronically involved, meet each condition from 1 to 4 plus need the services outlined in item 5.

Data from the Social Security Administration confirm the hypothesis that the concept of chronicity is tied to the fact of early childhood onset of disability. Twenty year's compilation of information on disabled adults entitled to social security benefits reveals that the conditions which contribute most to adult disabilities originating in childhood are mental retardation, cerebral palsy and epilepsy. Nearly 80% of those eligible for benefits as a result of disabilities originating in childhood fall within these diagnostic categories.

## What Was and Was Not Intended by the New Definition

Reference again to the same study reveals further insight into the implications of the new definition as compared to the old one:

- a) Intended: that the new definition would be
  - 1. less arbitrary as to inclusion in or exclusion from the DD population;
  - 2. more specifically focused on those whose impairment is "substantial"; and
  - 3. more in keeping with current habilitative trends toward functional approaches to defining and describing handicapped individuals.
- b) Intended: that the new definition would not be
  - 1. designed to eliminate those persons appropriately receiving services under the old definition (note, however, that the more mildly afflicted persons within the former diagnostic categories - mental retardation, etc. - are considered to be inappropriately labeled DD and would not, therefore, be included);
  - 2. designed to significantly increase the total DD population (considering especially that many individuals with mild afflictions are no longer considered developmentally disabled);
  - 3. designed for eligibility determination (specific operational definitions must be developed for that purpose; the larger definition is for planning and policy purposes);
  - 4. designed to segregate services but to make it easier to support services for the developmentally disabled population on the basis of shared needs.

An excerpt from the October 12, 1978, Congressional Record is intended to clarify further the issue of whether, under the new DD definition, some individuals currently receiving services might, in fact, be hereafter excluded:

"The conferees stress, however, that the definition agreed to is intended to cover everyone currently covered under the definition and is also intended to add other individuals with similar characteristics. In this definition, individuals with the conditions currently listed in the law - autism, cerebral palsy, dyslexia, epilepsy, or

mental retardation would be included if they meet the following criteria: manifestation prior to age 22, expectation of continuing indefinitely, substantial functional limitation, and need for multiple services for an extended period. It is not the intent to exclude anyone who legitimately should have been included under the definition in current law.

The conferees further wish to make clear their intent that the services provided under the Developmental Disabilities Assistance and Bill of Rights Act to individuals already receiving services should not be diminished as a result of the revised definition, although it is intended that the planning process and provision of services will immediately address all disability groups covered by the functional definition. In addition, as funding increases, it is expected that a reasonable proportion of any new funding will be directed to meeting the needs of DD individuals with those disabilities named in the existing law."

However apparent the general impression that the new definition is not to be used as the basis for exclusion of clients, the phrase "who legitimately should have been included under the definition in current law" opens up the possibility of interpretation that some individuals might possibly have been inappropriately included in the first place.

The phrase does indeed raise the issue of the legitimacy of initial inclusion of some persons as developmentally disabled under earlier federal laws. Although the new definition was not intended to exclude or eliminate legitimate recipients of services, and the intent was to incorporate all individuals who were appropriately included under the old definition, individuals with mild versions of the specific categories listed in the old definition were inappropriately considered to be developmentally disabled under the old definition, and would not be included within the new definition. The new definition is intended to ensure that appropriate attention is paid to those people in the categories previously listed which are most in need of services, not those with milder forms of the conditions.

The focus of the clarification of intent can therefore be narrowed to concentration on the word "appropriate", with the result that elimination from services for some individuals is, in fact, the end result.

#### The New Definition's Impact: Two Contrasting Examples

a) Simply because P.L. 95-602 has defined the developmentally disabled individual as someone who might well be handicapped other



than by the conditions of mental retardation, cerebral palsy, epilepsy or autism, it does not automatically follow that the impact of this expanded concept will be felt to any degree beyond that which is semantic.

A quadraplegic child who has been served by the programs under the administration of the Maternal and Child Health Bureau of the SDHES might now be considered developmentally disabled, while only a short time before the same label would have been considered by some professionals to be misapplied, denoting perhaps an inappropriate suggestion of mental retardation or a related disorder. The new definition, however, stresses the similarity of developmental impairment resulting in lifelong disability, rather than promoting the discrimination of etiological or symptomatic differences. The conditions under which the two impairments were manifested and the severity and chronicity of their impact in conjunction with the resultant need for some form of lifelong service - these are the defining factors under P.L. 95-602.

Should the designation of developmental disability then be deemed appropriate by MCH to apply to someone not previously so considered, it does not immediately follow that any programmatic impact will be felt either fiscally or through internal organizational change.

What does follow, however, is that the State Council itself, which is legally and fiscally bound by the definition within P.L. 95-602, must now take full cognizance of the programs within MCH, and of the clients served by those programs, with the same interest that has been generally demonstrated for those same factors within the Developmental Disabilities Division of SRS.

To a great extent, then, the issue of impact is defined from the direction of State Council to the state service agency, rather than by the reverse relationship. That is, the challenge of determining the scope of this impact of the expanded DD definition is to the Council first and then, through the influence of its planning and advisory role, to the state and private agencies which serve persons who the Council has, within the state plan, identified as developmentally disabled. To follow the MCH example further: that bureau might never consider certain of its clients to be DD even should the Council so identify them. Since, considering the scope of authority of P.L. 95-602, MCH is not obligated to do so, perhaps nothing beyond initial disagreement as to categorization is likely to result.

b) The Department of Institutions estimates that there are 1,600 chronically mentally ill, non-institutionalized adults in Montana. To be so classified, the individuals must meet the "Georgia criteria". Those meeting the criteria require mental health services over long, often indefinite, periods of time.

First, one of five factors must apply:

1. person has two or more hospital admissions within a 12-month period;



2. person has had a single episode of hospitalization since 1973 of at least one year duration;
3. person has been followed with medication only for at least one year;
4. person is enrolled in daycare or has been receiving supportive living services for a 6-month period;
5. person has high frequency of unscheduled contact with mental health system for more than 6 months.

In addition, three of the following must apply:

1. person is unemployed with markedly limited job skills and/or a poor work history;
2. person is employed in a sheltered setting;
3. person is unable to perform basic household management tasks without assistance;
4. person exhibits inappropriate social behavior which results in rejection by the community and requests for intervention by the mental health or judicial/legal system;
5. person is unable to procure appropriate public support services without assistance;
6. person requires public financial assistance for out-of-hospital maintenance (SSI, general assistance, supportive living funds, etc.);
7. person's natural environment has severe lack of social support systems (no close friends, person lives alone, no group affiliations, highly transient);
8. person is placed in a nursing home setting because of financial considerations and/or because less restrictive suitable environment is not currently available;
9. person is non-compliant recipient of mental health service when a clear need for such is evident.

There is some obvious semantic relationship between factors specified under the "Georgia criteria" and those listed within the DD definition of P.L. 95-602 under "major life activity". For instance, 1, 2 and 4 in the second set of criteria denote similar kinds of deficits as "capacity for independent living", "self-care", "economic self-sufficiency", and even "self direction" and "learning". The Department of Institution's Community Support Project has collected data on a small group of randomly-selected chronically mentally ill persons (who meet the specified criteria

to be so classified) and has discovered that at least 26% manifested symptoms before age 22 ("at least" because some of the others were of unknown age). For this group, then, the criteria of chronicity and of early onset, as specified in P.L. 95-602, have been met.

Another indication that there is perhaps a significant correlation between the kinds of problems encountered by the chronically mentally ill and those specified in the new DD definition is that of the increasingly prevalent use by the mental health system of service modalities usually associated with the community-based DD programs in Montana. Community Mental Health Centers in the state are using group homes for clients unable to live independently and, through the use of day treatment programs and sheltered workshops, have developed a program of day services similar to that of the community-based DD program. Most significant, perhaps, is the recent development of case management as an essential component of the comprehensive mental health system. Services for the chronically mentally ill have become less dependent upon the clinical skills of highly trained professionals. Increasingly, the ability of case managers to link together the available generic community services to meet the needs of the mentally ill person is being recognized as crucial to the client's ability to function outside institutional environments.

It is important, therefore, to note the striking similarity of this trend toward linking together available services to benefit the mental health client to that of the intent of the original and most recent federal DD legislation.

### Collecting Data on the New DD People

Tables 2.5 through 2.7 at the end of this Section, which are estimates of Montana's total DD population, contain figures for the estimated number of persons who have three or more of the functional limitations listed in the federal definition. The figures shown are based on the assumption that the DD population, under the new definition, comprise 1.57% of the total population. The reasoning behind utilization of this percentage figure is explained on page 38.

For purposes of data gathering, however, the State Council has utilized the list of handicapping conditions shown in Table 2.1, as a list of disabilities or handicapping conditions was felt to be more useful in obtaining information about persons served by the agencies contacted during the data gathering process than simply providing a copy of the federal definition and asking "how many persons do you serve who have functional limitations in three or more of these areas?" The list of handicapping conditions shown in Table 2.1 is by no means intended to be all-inclusive, rather it lists conditions which are likely to fall under the expanded definition of developmental disabilities. The table gives a brief description of each condition, the approximate age of onset, and the data

available on prevalence of each condition.

### "Operationalizing" the New DD Definition

Perhaps the most immediately striking impact of the new definition is semantic. Under P.L. 95-602, one could explain developmental disabilities by simply listing the diagnostic components. That the definition also contained descriptive information about developmental origin prior to age 18, the likelihood of indefinite continuation of the impairments, or the substantiality of their effects, was fundamental to a complete understanding of the intent of the law. Since, under P.L. 95-602, the definition intentionally omits any reference to diagnostic categories, the new definition's elements need to be operationalized. Although the old definition was not really operational, many treated it as such. The new definition is clearly not operational. Separate operational definitions must be developed not only to comply with directions from federal officials, but also to facilitate an understanding of the definition.

Within the scope of discussion here, operational means functional. The definition of DD from P.L. 95-602 is formal, but not functional. We can know something about the ideas behind the seven areas of major life activity simply by imagining what "learning" or "self-care", for instance, probably mean. However, when the words are accompanied by an explanation of specific operations of behavior, clarity is added.

Certainly there are advantages and disadvantages to the operational approach. An advantage is that the functional approach to defining populations is consistent with trends in federal programs. This approach aids planners because such definitions tend to relate to service needs. Avoided are obscure concepts and terminology, while encouraged is the development of instruments sensitive to the behavioral aspects of impairments.

However, with such an approach, several disadvantages arise: First, despite the trend toward a purely functional approach, few such definitions are currently active. No well-established means of classifying functional disabilities exists because the system is difficult to develop and tedious to use clinically. Second, because it is difficult to establish absolute criteria for levels of independent functioning. To establish criteria which are exhaustive of all possibilities within a functional classification, while mutually exclusive of all others, is nearly impossible. Third, little functional classification data exist, and they are neither uniform nor especially compatible.

Fundamental to the new definition was the intent to re-develop the concept of developmental disabilities so that the entire





TABLE 2.1 A LIST OF IMPAIRMENTS FOR POTENTIAL INCLUSION  
IN THE DD DEFINITION

IMPAIRMENT	DESCRIPTION	AGE OF ONSET	PREVALENCE
Childhood Psychosis	An impairment in the mental or emotional functioning - deviating from the expected norms of behavior	4 - 7 years	Too disparate
Emotional Disturbance	As above except children so labeled in this category showing symptoms of learning disabilities	School-age	Too disparate
Mental Illness	An impairment in the mental or emotional functioning - deviation from the expected norms of behavior	From childhood on	20 million in US; 215,573 institutionalized in '74
Mental Retardation	Significantly sub-average general intellectual functioning which is associated with impairment in adaptive behavior	Birth or injury; Manifests at different ages	2.8% of U.S. population
Muscular Dystrophy	Neuromuscular disease with progressive degeneration of the skeletal or voluntary musculature of the body; Five types; Duchenne is usually fatal	Duchenne type: 2-10 years; Varying ages for other types	200,000 of U.S. population
Osteogenesis Imperfecta (tarda - mild form)	A crippling, incapacitating disfiguring disorder of connective tissues with fragile, brittle bones	Birth or later in life	Estimate: 10,000 - 30,000 of U.S. population
Spina Bifida	A birth defect in which the vertebrae fail to develop around spinal cord	Birth	12,000 such children born each year
Tourette's Syndrome	A movement disorder which causes erratic, involuntary spasmodic muscular movements	Between 2 & 15 years	Undetermined Could be more than 1,000 cases, total
Blindness or Severe Visual Impairment	A serious impairment in visual acuity	Birth or injury	500,000 of U.S. population legally blind
Deafness	A whole or partial loss of the sense of hearing	Prelingual-birth to 3 years; Pre-vocational: to age 19 years	2,000,000 of U.S. population lack sufficient hearing to understand speech

TABLE 2.1 (CONT'D)

IMPAIRMENT	DESCRIPTION	AGE OF ONSET	PREVALENCE
Huntington's Disease	A degenerative disorder of the central nervous system, usually fatal	Genetic disorder present at birth (25 or so); Childhood form: 12-14 years	Estimate: 10,000 to 14,000; May be 3 to 4 times as many
Learning Disabled	The inability to learn, to perceive and/or to read, by accepted methods, despite normal or above-normal I.Q.	Birth	Severe: up to 10% of total school-
and		or	
Minimal Brain Dysfunction (Medical model)	As above, except that assault to the brain, depending on severity and area involved, may cause functioning retardation symptoms	Trauma	age population
Cerebral Palsy	Spasmodic whole or partial paralysis due to cerebral lesion	Birth or Trauma	.70% of U.S. population
Epilepsy	A convulsive disorder of the central nervous system due to abnormal electrical discharges of brain cells	Birth or Trauma	1.0% of U.S. population
Autism	Severe disorders of behavior and communication	Birth	.03% of U.S. population

population of DD persons will be more clearly and less arbitrarily defined, and the severely impaired more frequently served. Through the development of operational definitions, i.e., those based on functional limitations, or inability to perform certain tasks - an important aspect of the intent of P.L. 95-602 will be realized. A functional limitation is a reduced ability, on the part of an individual to perform a particular task or tasks.

It has also been emphasized by those studying the new definition that substantiality represents an inability to perform normal life activities, or implies either frequent assistance is needed from others in order to perform such activities or the assistance of devices expensive to maintain or replace. When considered together, these ideas lead to the conclusion that a substantial functional limitation is one which prevents the person from adequately performing any three of the seven major life activities. To be emphasized is not only the degree of limitation within any activity, but also the extent of overall limitation.

Examination of Tables 2.2, 2.3 and 2.4, all of which have been developed by different individuals or organizations who have studied the new definition, reveals that attempts to delineate specific criteria for each of seven major life activities have produced highly similar language. While those tables list suggested operational definitions of the seven activities of daily life, Table 2.4 also delineates specific tests by which the question will be determined as to which persons have which substantial functional limitations.

The Tables represent two approaches, each essential, to constructing operational definitions of functional limitations: the concept of explicitly describing an activity is essential to that of defining which persons will be affected by that description; likewise, the development of population estimates depends upon the prior development of specific criteria from the description. Table 2.3 contains a description of the activity and a set of criteria for determining whether to include a person in the DD population.

Inspection of the tables reveals evidence for the clarity of meaning added by the operational denotations. Obviously, other definitions are possible. Those suggested do, however, capture the flavor of the "functional" argument, and are inherent to the development of an understanding of some of the implications of P.L. 95-602.





TABLE 2.2 EXPLANATION OF AREAS OF MAJOR LIFE ACTIVITY

ACTIVITY	DEFINITION	EXAMPLES OF SPECIFIC ACTIVITIES OF SKILLS
Self Direction	Management and taking control over one's social and personal life. Ability to make decisions affecting and protecting one's own interests.	<p>Self Concept: self-esteem, self-confidence.</p> <p>Socialization: affect, emotion, social awareness, emotional stability, leisure time activities, community involvement.</p> <p>Initiative: responsibility, decision making</p> <p>Orientation: awareness of environment, responsiveness to environment.</p>
Capacity for Independent Living	Age appropriate ability to live without extraordinary assistance from other persons, especially to maintain normal societal roles.	<p>Housekeeping: cleaning, maintenance, making beds, cooking, laundry, care of clothing.</p> <p>Family Support: maintaining relationships, being a spouse, parenting.</p> <p>Money Management: budgeting, purchasing, keeping track of expenditures, using money.</p> <p>Health and Safety: selecting appropriate clothing, balanced nutrition, health and safety.</p> <p>Leisure Time Activities: recreation, cultural activities, religious activities, social activities, social activities, clubs.</p> <p>Using the Community Resources: using transportation, telephone, post office, stores, and other community resources.</p>

TABLE 2.2 (CONT'D)

ACTIVITY	DEFINITION	EXAMPLES OF SPECIFIC ACTIVITIES OF SKILLS
Economic Self-Sufficiency	Maintaining adequate employment and financial support. Ability to earn a "living wage," net, after payment of extra-ordinary expenses occasioned by the disability. Absence of dependence on family or welfare for financial support.	<p>Pre-Vocational and Vocational Skills: ability to perform tasks required for a job, ability to learn new skills as needed.</p> <p>Work Adjustment: promptness, work habits, adjustment to work environment.</p> <p>Job Finding: ability to locate appropriate work, interviewing skills, presentation of self</p> <p>Income: earning capacity.</p>
Economic Self-Sufficiency (cont.)		
Self Care	Daily activities which enable a person to meet basic life needs for food, hygiene and appearance.	<p>Eating: drinking, mealtime manners, use of utensils, mastication and swallowing.</p> <p>Hygiene: toileting, washing and bathing, tooth-brushing.</p> <p>Grooming: dressing, undressing, hair and nail care, care of clothing, overall appearance.</p>
Receptive and Expressive Language	Communication involving both verbal and non-verbal behavior enabling the individual both to understand others and to express ideas/information to others.	<p>Expressive: use of oral or sign language or other intelligible gestures or sounds, use of mechanisms (such as letter boards or typewriters) for expression, and communication with others, voice control.</p> <p>Receptive: understanding through listening, auditory comprehending, lip reading, comprehending other forms of communication (e.g. sign language, reading).</p>

TABLE 2.2 (CONT'D)

ACTIVITY	DEFINITION	EXAMPLES OF SPECIFIC ACTIVITIES OF SKILLS
Learning	General cognitive competence and ability to acquire new behaviors, perceptions and information, and to apply experiences in new situations.	<p>Cognition: ability to understand information, recognition.</p> <p>Retention: memory, knowledge.</p> <p>Reasoning: ability to generalize, to conceptualize, to see relationships among pieces of information, to use abstract concepts.</p> <p>Pre-Academic and Academic Skills: reading, writing, quantitative activities, shape and color recognition</p>
Mobility	Motor development and ability to use fine and gross motor skills. Ability to move one's person from one place to another with or without mechanical aide.	<p>Movement: crawling, walking, climbing, use of mobility and aids such as crutches, wheelchair, cane or walker.</p> <p>Gross Motor Control: balance, posture, sitting, standing, rolling.</p> <p>Fine Motor Control: manual dexterity, precision movements, ability to control or direct mechanical devices.</p> <p>Coordination: eye-hand, perceptual-motor, body-motor.</p>

TABLE 2.3 COMPONENTS OF THE SEVEN MAJOR LIFE ACTIVITIES

ACTIVITY	DEFINITION OF ACTIVITY	POTENTIAL LIMITATIONS
Self-care	Daily activities which satisfy personal needs for food, hygiene, safety and appearance.	Regular assistance is required in eating or drinking, and/or hygiene and/or assuring the individual's immediate personal safety.
Learning	Changes in an individual's behavior or perception; the process which results in such changes.	Requires aids and techniques in learning which require environments other than those usually assumed to be adequate, including: <ul style="list-style-type: none"> <li>- in the home or day care center, structured developmental play activities are needed, specific to the child's disability, rather than semi- or un-structured play.</li> <li>- in school, some instruction needs to take place in a sheltered classroom rather than in the mainstream.</li> </ul>
Mobility	Ability of the individual to negotiate distance using his or her own power or a personally controlled device.	Regular assistance or use of devices is required for life-support, locomotion, ambulation or mobility in the community.
Self-Direction	Ability of the individual to manage his or her personal and social behavior.	Requires regular counseling or supervision in dealing with self or group; requires behavior modification to achieve self-restraint, social interaction, self-respect or other adaptive behavior.
Economic Self-Sufficiency	Financial resources are available to meet both basic life support needs of the individual and his or her recreational needs.	Insufficient income or support for a person's (family's) basic and recreational needs.



TABLE 2.3 (CONT'D)

ACTIVITY	DEFINITION OF ACTIVITY	POTENTIAL LIMITATIONS
Receptive & Expressive Language	Ability to understand language of others; ability to communicate ideas through language. Language may be spoken, written, sign language or other gesturing.	Requires some use of interpreters or devices to communicate to the individual and/or others.
Capacity for Independent Living	Ability to maintain a full and varied life in the community with little or no regular outside intervention in the living situation.	Requires daily assistance for maintaining a full life in the community and/or in decisions about money management, housekeeping and related activities.



TABLE 2.4

SUGGESTED OPERATIONAL DEFINITIONS OF MAJOR LIFE ACTIVITIES

ACTIVITY	DEFINITION
	The Example of an Individual Who Has a Substantial Limitation is:
1. Self-Care	A person who has a long-term condition which requires that person to need significant assistance to look after personal needs such as food, hygiene and appearance. Significant assistance may be defined as assistance at least one-half of the time for one activity or a need for some assistance in more than one-half of all activities normally required for self-care.
2. Receptive and Expressive Language	A person who has a long-term condition which prevents that person from effectively communicating with another person without the aid of a third person, a person with special skill or with a mechanical device, or a long-term condition which prevents him/her from articulating his thoughts.
3. Learning	A person who has a long-term condition which seriously interferes with cognition, visual or aural communication, or use of hands to the extent that special intervention or special programs are required to aid that person in learning.
4. Mobility	A person who has a long-term condition which impairs the ability to use fine and/or gross motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the individual to move from place to place.
5. Self-Direction	A person who has a long-term condition which requires that person to need assistance in being able to make independent decisions concerning social and individual activities and/or in handling personal finances and/or protecting his/her own self-interest.
6. Capacity for Independent Living	A person who has a long-term condition that limits the person from performing normal societal roles or which makes it unsafe for that person to live alone to such an extent that assistance, supervision or presence of a second person is required more than half the time.
7. Economic Self-Sufficiency	A person who has a long-term condition which prevents that person from working in regular employment or which limits his or her productive capacity to such an extent that it is insufficient for self-support.





## Estimates of Montana's DD Population

The pages which follow contain tables with estimated numbers of DD persons in Montana, by region. As previously mentioned, the percentage figure of 1.57 was used to estimate the number of DD persons in the state. The 1.57% figure was derived from a report by one of the major studiers of the new federal definition (Boggs and Henney, 1979).

To arrive at the 1.57%, Boggs and Henney examined data collected for the "Report of the Survey of Income and Education" (SIE) and reported estimates of the developmentally disabled population. These data had been originally collected in 1976 by the Bureau of Census to determine the effects of chronic impairments on major life activities. Data gathering involved more than 100,000 assessment interviews. While Boggs and Henney caution that the SIE data tend to underestimate prevalence rates cited by some professional and consumer organizations (and to overcount frequencies in some older adult groups), they do, however, emphasize that these data share the advantages of being current and relevant to the DD population. Further these data represent rates of prospective utilization rather than of theoretical prevalence.

By surveying the raw data from the SIE report, Boggs and Henney estimated the percentages and numbers of individuals three years of age and older who demonstrated functional limitations in the seven major life activities before the age 22. For purposes of Tables 2.5, 2.6 and 2.7, the 1.57% prevalence rate has also been applied to the age group birth to three years, since it is assumed that population characteristics for those ages would be the same as for older age groups.

It should be noted that not all persons served in Montana's community-based DD system are included in the figures of estimated numbers of DD persons in the state. The reason for this is, of course, that not all mentally retarded, cerebral palsied, epileptic and autistic persons would fit within the federal definition of developmental disability. All persons served under the state definition are, however, included in the data concerning services provided by state agencies in Section 3 of the Plan. This variance will obviously skew any comparisons between Sections of the Plan relating to total number of "DD" persons in the state and total number of "DD" persons receiving services.



TABLE 2.5

## SUMMARY OF DD POPULATION BY AGE GROUPS

1981

GEOGRAPHICAL SUBDIVISION Planning Regions	STATE POPULATION	TOTAL STATE DD POPULATION	DD POPULATION BY AGE GROUPS										
			Which is Minority b) 3(4.8%)	AGE GROUP Pre-School No. & 5	AGE GROUP School No. & 6	AGE GROUP Adult No. & 7	AGE GROUP 65+ No. & 0						
1	Total	790,030	37,921	12,403	1.57	1,016	.082	2,695	.217	7,416	.598	1,276	.103
	Region I	103,089	4,948	1,618	1.57	138	.085	366	.226	940	.581	175	.108
	Region II	149,940	7,197	2,354	1.57	219	.093	514	.218	1,390	.590	230	.098
	Region III	160,939	7,725	2,527	1.57	205	.081	562	.222	1,503	.595	256	.101
	Region IV	189,840	9,112	2,980	1.57	230	.077	614	.206	1,817	.610	320	.107
	Region V	186,222	8,939	2,924	1.57	224	.077	639	.219	1,766	.604	295	.101
	a) State totals derived from "Montana Population Projections, 1980-2000", July, 1977, Research and Information Systems, Department of Community Affairs												
	b) Minority figured at 4.8% - derived from U.S. Bureau of Census, "Current Population Reports", series P-23, #67, Feb., 1978												
	c) 1.57% based on percentage of individuals with deficits in three or more of the seven major life areas. Note also that the estimated DD pop, which is based on the 1.57% factor is a figure significantly lower than the traditional 3% MR alone, or the sometimes quoted 5.44% for all DD persons, as defined by Montana state law.												

TABLE 2.6

## SUMMARY OF DD POPULATION BY AGE GROUPS

1982

GEOGRAPHICAL SUBDIVISION Planning Regions 1	STATE POPULATION		Which is Minority 3	TOTAL STATE DD POPULATION No. 4	DD POPULATION BY AGE GROUPS								
	Total 2	POPULATION			AGE GROUP Pre-School No. 5		AGE GROUP School No. 6		AGE GROUP Adult No. 7		AGE GROUP 65+ No. 8		
					No.	%	No.	%	No.	%	No.	%	
State Total	797,549	38,279		12,520	1.57	1,026	.082	2,717	.217	7,486	.598	1,289	.103
REGION I	104,479	5,024		1,640	1.57	140	.085	370	.226	953	.581	177	.108
REGION II	151,534	7,273		2,379	1.57	222	.093	518	.218	1,403	.590	233	.098
REGION III	162,700	7,809		2,554	1.57	206	.081	566	.222	1,519	.595	258	.101
REGION IV	191,412	9,287		3,005	1.57	232	.077	619	.206	1,834	.610	322	.107
REGION V	187,424	8,996		2,942	1.57	226	.077	644	.219	1,777	.604	297	.101

TABLE 2.7

TABLE 2.7

## SUMMARY OF DD POPULATION BY AGE GROUPS

1983

1983

GEOGRAPHICAL SUBDIVISION Planning Regions	STATE POPULATION Total	Which is Minority	TOTAL STATE DD POPULATION No.	DD POPULATION BY AGE GROUPS								
				4	AGE GROUP Pre-School No.		AGE GROUP School No.	AGE GROUP Adult No.		AGE GROUP 65+ No.		
					5	6		7	8			
1	805,068	38,643	12,639	1.57	1,036	.082	2,742	.217	7,558	.598	1,301	.103
REGION I	105,464	5,062	1,655	1.57	141	.085	374	.226	962	.581	180	.108
REGION II	152,963	7,342	2,401	1.57	223	.093	522	.218	1,417	.590	235	.198
REGION III	164,234	7,833	2,578	1.57	209	.081	571	.222	1,534	.595	260	.101
REGION IV	193,216	9,274	3,033	1.57	234	.077	625	.206	1,851	.610	326	.107
REGION V	189,191	9,081	2,970	1.57	229	.077	650	.219	1,794	.604	300	.101
							-					



## Service Needs of the DD Population

See Section 4 of the Plan for information on service needs of the estimated DD population in Montana.

## References and Credits

Much of the information in this Section of the Plan and many of the concepts expressed are credited to Keith McCarty, Professional Planning and Research Consultants, Inc., Helena, Montana. Mr. McCarty conducted a comprehensive assessment of the meaning and impact of the new federal definition under a grant from the State Council. Much of the material quoted from Mr. McCarty's report was gleaned from the following sources:

The Modified Definition of Developmental Disabilities: An Initial Exploration, E. Gollay

Program Issue Review: Defining the Developmentally Disabled Population, EMC Institute

A Numerical and Functional Description of the Developmentally Disabled Population in the United States by Major Life Activities as Defined in the Developmental Disabilities Assistance and Bill of Rights Act as Amended by P.L. 95-602, E.M. Boggs and R.L. Henney

The Prevalence of the Developmental Disabilities, EMC Institute



SECTION 3

EXTENT AND SCOPE OF SERVICES





## EXTENT AND SCOPE OF SERVICES

Section 3 of the State Plan contains a description of services currently available in Montana to the developmentally disabled. Generally, each of the components of Section 3 contains the following information.

- a) a description of the program of the agency providing the services;
- b) a description of the manner in which the services are provided;
- c) a chart or map illustrating the location of the providers of the services;
- d) current goals and objectives of the programs (goals and objectives for 1982 and 1983 will be included as revisions to this three-year plan in 1982 and 1983);
- e) Table 3.A, showing the services provided as they relate to the four priority service areas listed in P.L. 95-602; and
- f) Table 3.B, showing the numbers of persons served, again as the services relate to the four priority service areas.

The four priority service areas, which P.L. 95-602 intends the DD program should focus on, are as follows:

"Case management services" are services to assist in gaining access to needed social, medical, educational, and other services. The term includes: (1) follow-along services such as consultation and evaluation which ensure that the changing needs of the person and the family are recognized and appropriately met; and (2) coordination services which provide to persons with DD support, access to other services, and monitoring of that person's progress.

"Child development services" are services to assist in the prevention, identification, and alleviation of developmental disabilities in children. They include: (1) early intervention services; (2) counseling and training of parents; (3) early identification of developmental disabilities; and (4) diagnosis and evaluation of developmental disabilities.

"Alternative community living arrangement services" are services to assist in maintaining suitable residential arrangements in the community. They include in-house services, for example: personal aides and attendants, and other domestic assistance and supportive services; family support services; foster care services; group living services; respite care; and staff training, placement, and maintenance services.

"Nonvocational social-developmental services" are services to assist in the performance of daily living and work activities, for example: day activities, transportation, financial matters, recreation, civic concerns, and personal-social matters.

As can be seen by reviewing Tables 3.B, there is very limited information available which would make possible the separating of persons who fit within the new federal definition of "developmental disability" from all other clients served by the programs described herein. Except in the case of specific programs wherein it is obvious that all persons served fit within this definition (Boulder River School & Hospital, Eastmont Human Services Center, etc.), it is not indicated on Tables 3.B how many of the "new" DD persons are actually served by these programs.

Also in relation to Tables 3.B:

- information about capacities of programs to serve additional persons is, for the most part, unavailable
- in cases in which a program provided a state total for numbers of persons served, the total was divided among the regions according to the percentage of the total state population in the regions
- generally, "constraints to services" which were provided by program directors, apply to all priority service areas
- all figures in Tables 3.B show the number of persons served annually, unless otherwise indicated.

Some separation of program from administering agency has been done for purposes of clarity. For instance, although Warm Springs State Hospital, Eastmont Human Services Center and Boulder River School & Hospital are all administered by the Mental Health & Residential Services Division of the Department of Institutions, those three institutions are the subjects of separate components of Section 3.

Section 3

AGING SERVICES





## AGING SERVICES

The Federal Level: The Administration on Aging, (A.O.A.) located in the Office of Human Development of the Department of Health, Education and Welfare, is the responsible Federal agency in the network. AOA serves as the Government's chief advocate for the elderly, coordinates all Federal programs that concern the elderly, and allocates funds for all programs authorized under the Older Americans Act.

The relationship between AOA, Montana's SRS Aging Services Bureau and the seven Area Agencies on Aging was primarily established by the 1973 amendments to the Older Americans Act. AOA, through the Denver Regional Office, grants funds to Montana on the basis of an annual state plan. The state plan identifies statewide program objectives and is, for the most part, a collation of the individual plans submitted by the Area Agencies on Aging.

The State Level: The Aging Services Bureau is the focal point of all programs for the aged in this state. The Bureau is the over-all planner, coordinator and evaluator of all federal and state funded programs designed to serve the elderly of Montana. By regulation, the only direct service that the state agency can provide is information and referral. Consequently, the primary role of the Aging Services Bureau is that of advocacy and state-level administration of programs funded for the elderly. Through a staff of eleven, including field coordinators, the Bureau distributes state and federal funds, evaluates and assesses programs, provides technical assistance and training for a statewide system for Area Agencies and service providers that deal directly with the older citizens of Montana.

The Local Level: Area Agencies on Aging, of which there are seven in Montana, are the "grass roots" administrators of programs and services for seniors. The Area Agencies, mandated by the 1973 amendments to the Older Americans Act, are charged with the continuing process of planning services for older persons at the local level, coordinating the actual delivery of needed services, full utilization of existing resources, and development of new or additional resources. Each of the seven Area Agencies in this state is responsible for a specific geographic area of the state.

In the planning process for a year's service activities, objectives are established by the Area Agencies. The Areas individually develop service plans that are submitted to and approved by the Aging services Bureau. From the seven Area Plans a State Plan is generated which is submitted to and approved by the AOA.

Through this process and with the interaction and coordination of all three levels (federal, state and local), the "Aging Network" provides and coordinates services designed to enhance and improve the lives of Montana's senior population.

COUNTIES COMPRISING AREA COUNCILS ON THE AGING  
AREA VII is comprised of six of the state's

COUNTIES COMPRISING AREA COUNCILS ON THE AGING AREA VII is comprised of six of the state's

seven Indian Reservations (Blackfeet, Northern  
Cheyenne, Crow, Fort Belknap, Fort Peck & Rocky Boy)

Target Population: The Older Americans Act requires that all citizens over 60 years of age be served, but that those individuals with the greatest economic and social needs be given particular attention.

Major Overall Goal of Program: To prevent or reduce incidence of inappropriate and/or early institutionalization of Montana Senior Citizens.

#### SERVICES PROVIDED

The Information and Referral Program: A toll-free telephone to the Governor's Office through his Citizen Advocate. The only program administered directly by the state office. The major purpose of the Montana Information and Referral is not to deliver the services requested, but to see that the agency responsible for service delivery does its job. It is very difficult for an agency to not respond to a specific individual with a specific problem when they know that a community advocate is going to check to see that attention was addressed to the client. A very high percentage of inquiries are with respect to a problem or mix-up with Social Security benefits. The working relationship with the Information and Referral network and SSA has developed to a point that most difficulties are resolved within hours. Prior to this network and the working relationship, some cases were unresolved for years.

Legal Services: For FY 80, the Bureau will contract with the Montana Legal Services Corporation (MLSC) for the Long Term Care Ombudsman Service. This group will be responsible for all requirements of the program and will coordinate their efforts with the Montana Aging Network. A fulltime Nursing Home Ombudsman will be employed by MLSC to investigate and resolve complaints made by or on behalf of older persons. MLSC will continue to employ a fulltime attorney to supervise this Ombudsman and the activities of this project. Both staff persons will be responsible to coordinate their efforts with the Information and Referral Program as a means of further coordination and contacts with nursing home residents.

Transportation Program: Transportation services for senior citizens include reduced fares on available public transportation; volunteer drivers reimbursed for mileage, and scheduled and unscheduled bus, van and limousine services. The objective of this program is to provide 34,629 units of transportation for 974 senior citizens across the state. The program will provide transportation to medical facilities, shopping centers, social events, senior centers and other community facilities and resources in order to prevent institutionalization and maintain independent living situations. Those eligible for this service are senior citizens age 60 and above and Native Americans over age 45.

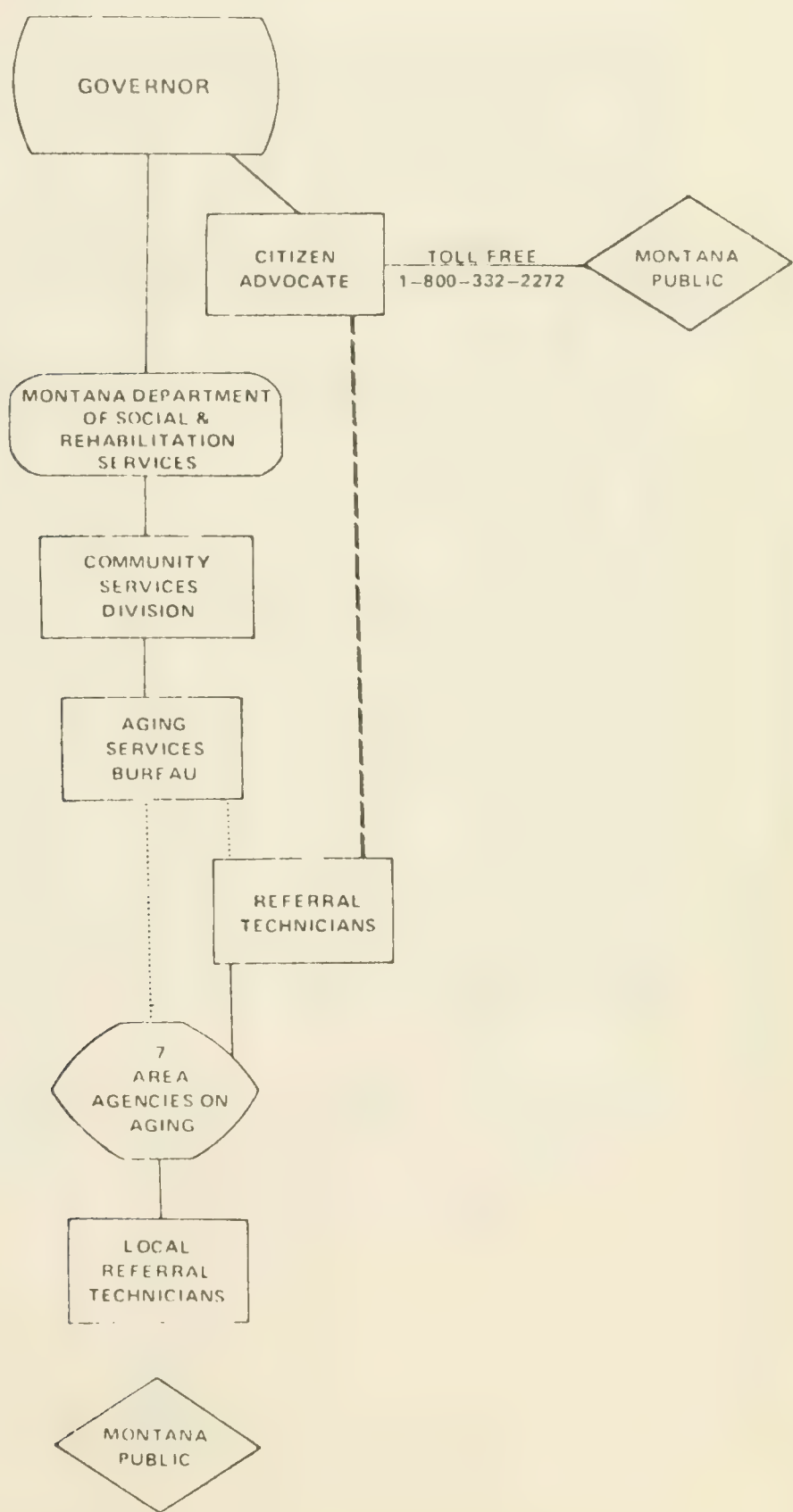


Homemaker/Home Chore Services: Homemaker/Home chore services include home management, home maintenance and limited personal care services to be provided by privately contracted and supervised homemakers to senior citizens in order to maintain independent living situations. The objective of this program is to provide 31,337 units of homemaker/home chore services to 1,811 senior citizens in order to maintain independent living situations and prevent premature institutionalization. Those eligible for services are senior citizens 60 and above and Native Americans over age 45 who qualify under SSI, Medicaid, or 80% Median Family Income. The program is not available in Region I.

Nutrition Services: Nutrition services include the provision of nourishing, congregate meals in a community setting and the preparation and delivery of nourishing meals to the homes of senior citizens who are unable to obtain or prepare them. The objective of this program is to provide 119,928 congregate and home delivered meals to 1,512 senior citizens across the state. The program provides less than three meals per day and is not designed to meet the full nutritional needs of the individuals. Those eligible for this service are senior citizens age 60 and above and Native Americans over age 45.

Outreach Services: Outreach services are assisting with access to a combination of the above-mentioned services as are needed by individuals eligible for those services, as well as senior citizens centers and area agency information and referral program and are designed to provide public awareness of Aging Services Bureau programs and referral to those programs.

MONTANA INFORMATION AND REFERRAL/OUTREACH STRUCTURE





## OBJECTIVES FOR 1979

To standardize contracts used by Title VII Projects by September 30, 1979.

To reduce the home-delivered meals served by Title VII to a statewide percentage of 25% by September 30, 1979.

The Aging Services Bureau, through the Aging Services Network, will conduct a survey of all senior citizen centers statewide by September 30, 1979.

Survey recipients of all Older Americans Act service projects to determine percentage of participation by low-income and minority senior citizens by September 30, 1979.

Increase the effectiveness and coordination of all Human Service Programs at community, county and PSA levels through the individual County Councils on Aging and the Area Agencies by September 30, 1979.

To improve the availability of in-home services to residents of low-income housing projects by September 30, 1979.

To implement a formal agreement with the Montana Nursing Home Association by September 30, 1979.

Co-sponsor a contest within the public school system designed to counteract the early development of negative stereotypes about older persons by September 30, 1979.

Expand monthly Information and Referral report to include consumer watch information by May 31, 1979.

Increase the in-house management capabilities of Title VII projects by September 30, 1979.

Implement a formal agreement with the Mental Health and Residential Services Division of the Department of Institutions by September 30, 1979.

State: Montana

FY 1979

BUDGET FOR AGING SERVICES

TITLES III, V, VII AND XX  
RESOURCE ALLOCATION PLAN  
BY 60/20/20 FORMULA

PLANNING AND SERVICE AREA	TITLE III		TITLE V	TITLE VII	TITLE XX	TOTAL
	AREA AGENCY ADMINISTRATION	SOCIAL SERVICES				
I	\$16,228	\$86,597	\$26,904	\$164,364	\$84,098	\$379,191
II	16,229	118,140	36,704	218,770	102,717	402,550
III	16,229	116,698	36,256	311,100	116,630	596,913
IV	16,229	64,079	19,908	140,397	51,868	292,481
V	16,229	74,430	23,124	186,806	60,158	360,747
VI	16,229	133,102	41,352	216,063	107,529	514,275
VII	16,229	50,702	15,752	(142,070)*	(19,747)*	22,813 (161,217)*
<u>TOTAL</u>	\$113,602	\$663,748	\$200,000	\$1,237,500	\$523,000	2,737,191

\*Administered through subcontracts from Planning and Service Areas I, II, III, and IV.



TABLE 3.A

## SERVICES PROVIDED

Agency: SRS  
Program: Aging Services

## ALTERNATIVE COMMUNITY LIVING SERVICES

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Minority Services
1. Homemaker/Home-chore	X	X			X			X
2. Nutrition	X	X						

TABLE 3.A

## CASE MANAGEMENT SERVICES

Service	Assisting w/Access	Consultation w/ Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
1. Information & Referral	X	X	X	X			
2. Outreach	X	X	X				
3. Legal Services	X	X	X	X			

TABLE 3.A

## NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/Day Activities
1. Transportation	X	X	X	X	X	
2. Nutrition	X		X			



# NUMBERS OF PERSONS SERVED

Table 3.5

AGING SERVICES (All Priority Service Areas)

REGION	All Services Provided		CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO
I	Unk.													
II	Unk.													
III	Unk.													
IV	Unk.													
V	Unk.													
VI	Unk.													
VII	2525 (Indian)													
State-wide	74970													

Constraints to services apply to all priority service areas:

1. Funding
2. Public Awareness
3. Lack of sufficient funds for training in the aging process and the needs of the elderly.

Section 3

BOULDER RIVER SCHOOL & HOSPITAL



## BOULDER RIVER SCHOOL & HOSPITAL

Under state law (53-20-101 through 165 and 53-20-501, MCA 1979) the primary functions of Boulder River School & Hospital (BRS&H) are the care, treatment, training, education and necessary medical treatment of mentally retarded persons.

BRS&H is the only full-range institution in the State for the care, treatment, training, education and necessary medical care of mentally retarded persons. As such, the purpose of the institution is to secure the treatment and habilitation as will be suited to the needs of each individual, and to assure that such treatment and habilitation are skillfully and humanely administered with full respect for the person's dignity and personal integrity.

The operation of BRS&H is accomplished by three program units. A description of these programs follows.

### Administration Program

The Administration Program is responsible for providing overall direction for the operation of the institution. The program provides support services in the areas of fiscal, personnel, purchasing/warehouse, inservice training, clerical and other administrative functions of the institution.

### Care and Custody Program

The Care and Custody Program is responsible for the total care of the people in residence at all times; it includes residential living supervision, training, and providing direct services to meet the basic needs of shelter, clothing, health care, food and provision of the comprehensive continuum of care for each person.

### Developmental Program

The Developmental Program provides training, teaching, therapy, psychological and social services. Its primary responsibility is to provide these services to the people in residence; its secondary responsibility is to develop techniques and methods for treating the problems associated with mental retardation.

The following Table indicates the budgets and staffing for BRS&H for the 1980-81 biennium.

-----

BOULDER RIVER SCHOOL AND HOSPITAL BUDGET

FY 80  
\$8,175,415

FY 81  
\$8,338,929

BOULDER RIVER SCHOOL AND HOSPITAL  
AUTHORIZED FULL TIME EMPLOYEES

FY 80  
488.10

FY 81  
468.26

-----

Services

The core treatment/training services offered at BRS&H are as follows.

Education

The formalized training and education conducted by certified special education teachers and has as one of its major purposes the objective of providing to residents an opportunity to gain physical, social, emotional and intellectual skills, in order that each person can develop to his individual potential.

Physical Therapy

Under a physician's orders, this department provides habilitative and rehabilitative services to the residents. These services include developmental exercises, correct positioning, feeding, training, group exercise, gait training, and use of modalities, and measuring for orthopedic shoes. Adaptive equipment and wheelchairs are provided for residents as needed. An orthopedic surgeon holds a weekly orthopedic clinic for residents referred by staff physicians. The therapists provide consultation services and inservice training to cottage staff and evaluate all residents at least once annually.

Psychology

Yearly formal evaluations are done for all residents. Other services as requested or indicated include direct therapy, staff consultation, parental consultation, habilitation planning, and consultation with outside agencies.

Audiology

Provides assessment of hearing capabilities, consultation on these findings, and approaches for professional and paraprofessional staff to use in connection with hearing problems. All residents receive impedance assessment during the year. For some, puretone testing, which requires training, is needed. Amplification is recommended for others.



## Title I

This is a federally-funded program for children ages 3 to 21, which provides pre-verbal skill development, social language skills, sensory motor development and training for response to puretone audiometric testing.

### Speech Therapy

Provides training in receptive and expressive communication skills. This includes development of alternate communication systems in non-verbal individuals.

### Recreation

The recreation department provides recreation therapy and training for all residents by providing movies, swimming, bus rides, holiday functions, physical education classes, pre-game and play-ground equipment training, training in gross and fine motor development, arts and crafts, game room skills, social and music skills.

### Living Areas

Includes one-to-one formal training sessions, informal training sessions and activity training sessions carried on by Habilitation Aides and Habilitation Training Specialists. The training curriculum includes self-help skills, language (verbal or otherwise), object identification, shopping skills, social skills, eating and table manners, and elimination of maladaptive behaviors.

### Medical

Includes x-ray, pharmacy, laboratory, nursing, hospital and physician services. A wide array of medical consultants are available as needed. Provides annual physical examinations for each person and provides medical care as needed to each person.

### Dental

Provides semi-annual examinations for each person as well as preventive care and repair of teeth as necessary. Provides consultation and inservice to cottage personnel in the area of oral hygiene.

### Occupational Therapy

Provides therapy and training aimed at developing gross motor, fine motor, perceptual motor and functional skills of the upper portion of the body. Programs are developed to improve range of motion of the upper limbs, eating skills and oral function, head and trunk control, tone normalization, sensory integration and sensory motor integration and bi-manual function.

## Social Services

Social workers write placement referrals, social histories and discharge summaries, do individual counseling for the people in residence and parents/guardians regarding rights or privileges, act as advocates for the people in residence, investigate placement possibilities and transport people on placement.

## Foster Grandparents

The Foster Grandparents Program provides meaningful part-time volunteer opportunities for older persons to render supportive, person to person services to the children in such areas as; education activities, love and affection, taking walks, feeding and socialization.

## Individual Habilitation Plans

Each person residing at BRS&H has an Individual Habilitation Plan (See Section 8 of the Plan for more information). An interdisciplinary team sets long- and short-range goals at scheduled IHP meetings. Monthly updates and a yearly review are required on each IHP.

The Plan of Service consists of: (1) prioritized unmet needs to be provided the individual; (2) names of persons and departments responsible for training; (3) training scheduled (hours per day, days per week, phase and step information, entry data and exit data); and (4) criteria for placement from BRS&H.

## Staff Development Programs

See Section 6 of the Plan for information on staff training.

## Population

The Table on the following page describes the BRS&H population by sex, age group, levels of retardation and racial distribution.

## Current Goals & Objectives

- (a) To provide care for a maximum of 242 people, 365 days a year. This includes: a) a one-to-one overall direct care staff ratio; b) maintenance and operation of living environment; c) provision of adequate laundry services; d) provision of nourishing meals as well as required therapeutic diets; and e) provision of preventive and acute health care comparable to that provided in the community.

BOULDER RIVER SCHOOL AND HOSPITAL  
AGE BY SEX BY LEVEL OF RETARDATION  
SUMMARY OF ALL COTTAGES  
FREQUENCY

AGE GROUPS

LEVELS OF RETARDATION

	UNKNOWN	NORMAL	MILD	MODERATE	SEVERE	PROFOUND	TOTAL	PERCENT.
<b>MALES</b>								
0-5 . . .	0	0	0	0	0	0	0	( 0.0)
6-12. . .	0	0	0	0	1	7	8	( 3.2)
13-17 . .	0	0	0	1	0	12	13	( 5.2)
18-21 . .	0	0	1	3	3	14	21	( 8.4)
22-25 . .	0	0	1	4	4	16	25	( 10.0)
26-30 . .	0	0	1	1	4	23	31	( 12.4)
31-40 . .	0	0	1	6	2	21	30	( 12.0)
41-50 . .	0	0	1	6	0	9	16	( 6.4)
51-60 . .	0	0	1	3	0	6	10	( 4.0)
61-64 . .	0	0	0	0	0	1	1	( 0.4)
65-70 . .	0	0	0	0	0	2	2	( 0.8)
71-80 . .	0	1	0	0	0	1	2	( 0.8)
TOTAL. .	0(0.0)	1(0.4)	8(3.2)	24(9.6)	14(5.6)	112(44.6)	159	( 63.3)
<b>FEMALES</b>								
0-5 . . .	0	0	0	0	0	0	0	( 0.0)
6-12. . .	0	0	0	0	0	3	3	( 1.2)
13-17 . .	0	0	0	0	1	6	7	( 2.8)
18-21 . .	0	0	0	1	1	12	14	( 5.6)
22-25 . .	0	0	0	0	0	12	12	( 4.8)
26-30 . .	0	0	0	0	0	15	15	( 6.0)
31-40 . .	0	0	1	3	2	23	29	( 11.6)
41-50 . .	0	0	0	1	1	5	7	( 2.8)
51-60 . .	0	0	0	2	0	1	3	( 1.2)
61-64 . .	0	0	0	0	0	1	1	( 0.4)
65-70 . .	0	0	0	0	0	1	1	( 0.4)
71-80 . .	0	0	0	0	0	0	0	( 0.0)
TOTAL. .	0(0.0)	0(0.0)	1(0.4)	7(2.8)	5(2.0)	79(31.5)	92	( 36.7)
<b>BOTH SEXES</b>								
0-5 . . .	0	0	0	0	0	0	0	( 0.0)
6-12. . .	0	0	0	0	1	10	11	( 4.4)
13-17 . .	0	0	0	1	1	18	20	( 8.0)
18-21 . .	0	0	1	4	4	26	35	( 13.9)
22-25 . .	0	0	1	4	4	28	37	( 14.7)
26-30 . .	0	0	3	1	4	38	46	( 18.3)
31-40 . .	0	0	2	9	4	44	59	( 23.5)
41-50 . .	0	0	1	7	1	14	23	( 9.2)
51-60 . .	0	0	1	5	0	7	13	( 5.2)
61-64 . .	0	0	0	0	0	2	2	( 0.8)
65-70 . .	0	0	0	0	0	3	3	( 1.2)
71-80 . .	0	1	0	0	0	1	2	( 0.8)
TOTAL. .	0(0.0)	1(0.4)	9(3.6)	31(12.4)	19(7.6)	191(76.1)	251	(100.0)

RACIAL DISTRIBUTION

White . . . . .	230	91.6%
Indian . . . . .	19	7.6%
Spanish American. . . . .	0	0.0%
Mixed . . . . .	2	0.8%
TOTAL. . . . .	251	100.0%

- (b) To provide treatment, training, education and necessary medical treatment in the least restrictive available environment, regardless of age, degree of retardation or handicapping condition. This includes: a) appropriately trained habilitation staff; b) Individual Habilitation Planning and Evaluations; c) Communications (speech, audiology); d) Education; e) Foster Grandparents; f) Occupational, Physical and Recreational Therapies; g) Psychology; and h) Religion.
- (c) To provide administrative direction and support on behalf of the institution. This includes but is not limited to: a) personnel; b) payroll; c) fiscal; d) clerical; e) data processing; f) labor relations; and g) staff development.
- (d) To participate in the planning for deinstitutionalization, assist in the development and coordination of community-based services, provide ongoing social services to families and provide public information regarding the institution. This includes, but is not limited to: a) referral preparation; b) attendance at community Individual Habilitation and Education Planning meetings; c) assisting regional staff, parents, potential group home and foster home persons at the institution and in the community; d) placements of people from the institution; e) coordination of transfers of people from WSSH and Galen to this institution and the community; and f) provision of information to state, private and local organizations, parents and legislators as necessary and requested.



# SERVICES PROVIDED

Agency: Department of Institutions  
Program: BRSH

## CASE MANAGEMENT SERVICES

Service	Assisting w/access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-up Along	Evaluation of Cases
1. Education					X		X
2. Physical Therapy					X		X
3. Psychology		X	X	X	X		X
4. Audiology					X		
5. Title I				X	X		X
6. Speech Therapy					X		
7. Foster Grand-parents				X			
8. Social Services	X		X			X	

## Table 3.A

### CHILD DEVELOPMENT SERVICES

Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
1. Physical Therapy	X				X	
2. Psychology		X	X	X	X	
3. Audiology	X		X	X		
4. Occupational Therapy	X		X	X		
5. Social Services		X				



TABLE 3.A SERVICES PROVIDED

Service	NONMOTIONAL SOCIAL-DEVELOPMENTAL SERVICE					Agency: Dept. of Institutions Program: MSHS	
	Assisting with Daily Living	Transport- tation	Financial Assistance	Recreation	Training in Personal/Social/ Civic Matters	Work/Day Activities	
1. Education	X				X		
2. Title I					X		
3. Speech Therapy					X		
4. Recreation				X			
5. Living Areas	X				X		
6. Social Services	X		X				
7. Foster Grandparents				X	X		

Table 3. A

MEDICAL SERVICES

Service	Pharmacy	Laboratory	Nursing	Consultant	Diagnostic	Dental
BRS&H	X	X	X	X	X	X

Table 3.B

## CASE MANAGEMENT - BRS&amp;H

REGION	Assisting with Access		CAPACITY FOR MORE			Follow Along		CAPACITY FOR MORE			Coordination of Services		CAPACITY FOR MORE			Other Services		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I																				
II																				
III																				
IV																				
V																				
BRS&H	251	251				717	717				502	502				251	251			

Totals in each service category are total number of service CONTACTS, not total people served.

The following constraints to services relate to all priority service areas unless otherwise specified:

1. Need additional direct care positions in order to provide for the diverse needs of the people residing at BRSH.
2. All people residing at BRSH need more hours of training than they are presently receiving.
3. There is currently a shortage of physical therapy personnel to serve all the people needing this service.
4. There is also a shortage of occupational therapy personnel to serve all the people needing this service.

# NUMBERS OF PERSONS SERVED

Table 3. B CHILD DEVELOPMENT SERVICE - BRS&H

REGION	Early Intervention		CAPACITY FOR MORE			Counsel- ing of Parents		CAPACITY FOR MORE			Training of Parents		CAPACITY FOR MORE			Other Services		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I																				
II																				
III																				
IV																				
V																				
BRS&H	50	50	X			169	169				66	66				251	251			

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Table 3. B NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES - BRS&H

REGION	Assisting with Daily Living		CAPACITY FOR MORE			Counsel- ing of Parents		CAPACITY FOR MORE			Training of Parents		CAPACITY FOR MORE			Other Services		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I																				
II																				
III																				
IV																				
V																				
BRS&H	241	241									1561	1561								

Section 3

CORRECTIONS (DD OFFENDERS)





## CORRECTIONS (DEVELOPMENTALLY DISABLED OFFENDERS)

Establishing the exact number of developmentally disabled inmates in any penal institution has always been a problem, not only for Montana, but in other states as well.

Miles B. Stantamour of the President's Committee on Mental Retardation has written quite extensively on this topic. He states that, because there is no standard definition of what constitutes mental retardation, identification of such inmates is very difficult. Montana State Prison has chosen to use the definition accepted by the American Association on Mental Deficiency. Mental retardation is described as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." An I.Q. measurement is also used, and is broken down in the following way: 81-90 mild, 71-80 moderate, 60-70 profound. This operational definition allows us a better opportunity to meet the needs of all inmates in prison.

In addition to the mentally retarded, there are also those inmates who are suffering from epilepsy and cerebral palsy.

There are approximately 25 developmentally disabled\* inmates incarcerated at Montana State Prison at the present time. These inmates are identified through the use of the Stanford Achievement Test, Quick Test, Kuder Preference Test, Minnesota Multiphasic Personality Inventory and medical records. The functional level of these inmates is rather high. Most lower functioning people are usually diverted to other facilities or institutions by the court.

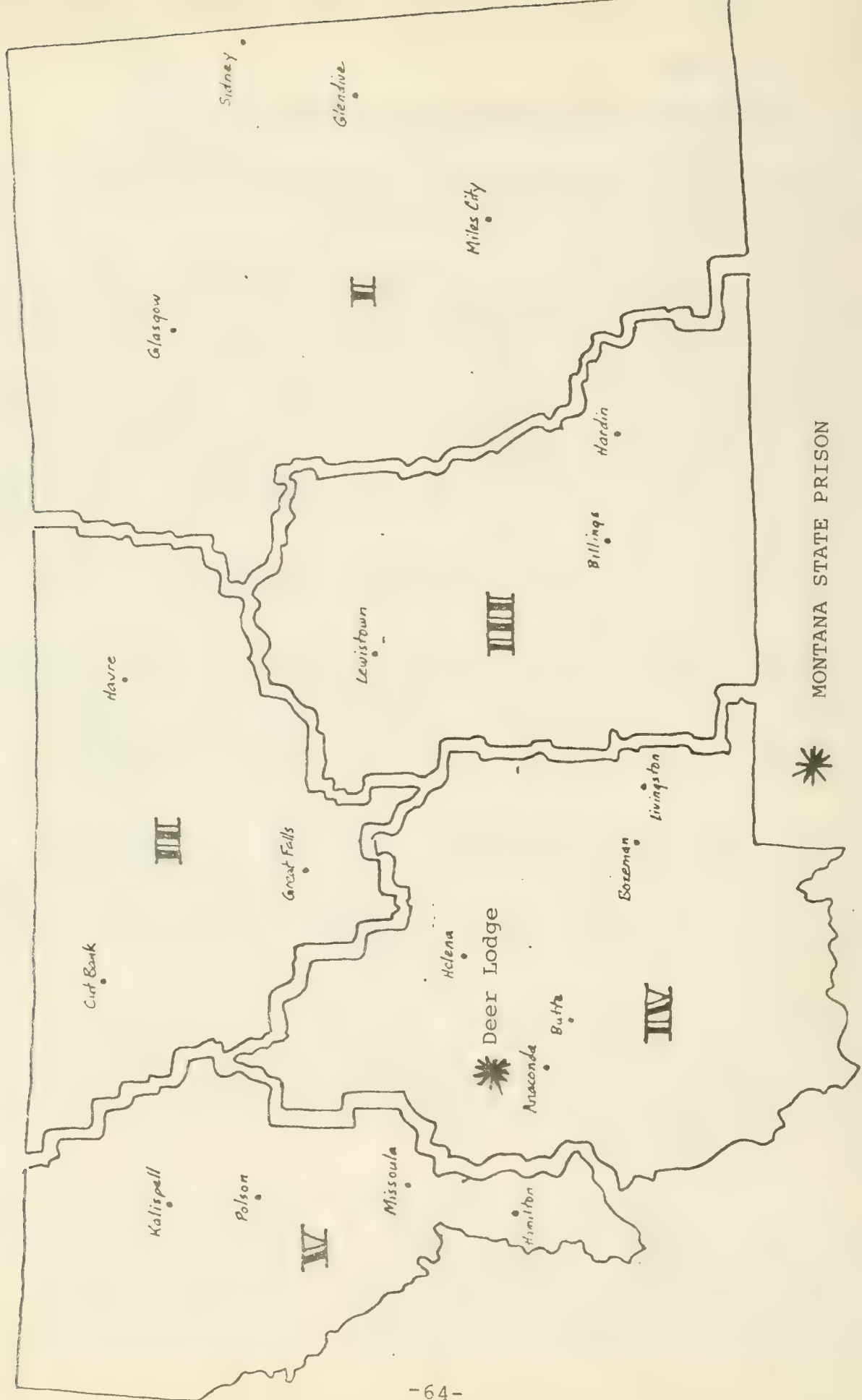
The majority of these inmates are placed in an IGP program. This is essentially a group counseling program, which addresses various problems of the individual. This program is designed to help the individual adjust to the institution; decrease his dependence; and begin to establish release plans. However, because we do not have the appropriate staff or facilities to address the needs of these people, only limited success can be expected from such a program.

Experts in the field seem to agree that the most appropriate program for such people should be built around a sheltered workshop concept. Montana State Prison lacks the necessary staff and equipment to establish a program to fully meet the needs of such people. Such a program would require the addition to the prison staff of one halftime psychologist, one special education teacher, one social worker, and a clerk-typist.

Developmentally disabled offenders provide a challenge to both the corrections professionals, as well as those who work with the mentally handicapped. In 1977, people from both professions met to discuss the problems of the DD offender. One of the primary recommendations of the Charleston Symposium was to establish a community-based facility which would serve as a combination sheltered workshop-halfway house to serve such inmates and parolees. Such a program might prove beneficial to all involved.

\*Pursuant to Montana state law

MONTANA



SERVICES PROVIDED

TABLE 3.A

Service	CASE MANAGEMENT SERVICES					Agency: Dept. of Institutions	
	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Program: DD Offenders Follow-Along	Evaluation of Svcs. Provided
Montana State Prison	X	X	X		X		X

## NUMBERS OF PERSONS SERVED

Table 3. B

REGION	Assisting with Access			CAPACITY FOR MORE			Consultation with Family or Client			CAPACITY FOR MORE			Coordination of Services			CAPACITY FOR MORE			Monitoring of Client Progress			CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT				
MT. State Prison	25	25	X			25	25	X			25	25				25	25	X			25	25	X	

Constraint applies to all services: Lack of funding to provide adequate services

Table 3. B

[illegible]

### Section 3

#### DEAF/BLIND PROGRAMS





## DEAF/BLIND PROGRAMS

Within the period 1963 through 1965, approximately 20,000 infants were born with handicapping conditions resulting from an epidemic of maternal rubella. A significant number of these children were born both deaf and blind.

In 1969, Federal legislation under Title VI-C Public Law 91-230 established eleven Regional Centers around the nation. Their primary responsibility was to create programs and provide case finding and diagnostic services for Deaf/Blind children.

In November 1971, the Montana School for the Deaf and Blind (MSDB) was selected by the State Office of Public Instruction as the flow-through agency in Montana to administer the funds for the Title VI-C Deaf/Blind Multi-Handicapped Program. At that time Montana was made a part of the Northwest Regional Center along with Alaska, Idaho, Washington and Oregon.

On January 12, 1972, a deaf/blind program was initiated at Boulder River School and Hospital. Because many of the Deaf/Blind children were already living in the institution and because of the supportive services which were made available there--medical doctors, orthopedic specialist, dentist, ophthalmologist, audiologist, physical therapist, psychologist, speech pathologist, etc.--it was the most appropriate setting for delivery of services.

The BRS&H program started with 18 children, two teachers and 4 aides who held classes in both the school building and in a double-wide trailer. Soon there were five more children in the state identified as deaf/blind and they, too, were moved to BRS&H.

Few of the children could walk, feed or dress themselves, they were not toilet-trained, did not relate to their peers or to those who worked with them and they had a multitude of inappropriate behaviors.

However, the program ran smoothly, with teachers, aides, foster-grandmothers and child-care workers working together toward accomplishing the long-range goal that had been set: "To develop the childrens' independence, awareness of their environment, functional abilities, cognition, physical development, etc."

During this time, the program was privileged to have five Boston College students, who were working toward their Masters Degrees in Deaf/Blind, complete their practicum in the program.

Three years later five of the higher functioning children were moved to the MSDB, where they lived in the dormitory and had their own classroom in the school with the deaf and the blind children. A teacher and two aides moved from the BRS&H program with them.

As children in the community were identified as deaf/blind, and placed in either multi-handicapped programs in the public schools or were served at home by home trainers, a consultant/coordinator provided assistance and materials to the teachers, parents and home trainees.

Assistance in programming, curriculum development, and teaching techniques has been available for the entire staff through consultation and in-service training from Northwest and Mountain Plains Regional Offices, Teaching Research, Boston College and other state and nationally-recognized authorities.

Every effort is used to take advantage of professionals in related fields in providing direct services to parents of home-bound children.

In 1977, the first group homes specifically for Deaf/Blind children were developed in Great Falls through the cooperative effort of the state Developmental Disabilities Division and the MSDB. Each home provided care for 5 children. In addition, a third home has been opened recently, which houses two deaf/blind children with other developmentally delayed children. A continuing working relationship is ongoing between the group homes and the deaf/blind staff of MSDB. Implementation of prevocational strategies and goals is occurring in the classroom and also in the group homes. Classroom teachers go into the homes for follow-through on training.

There are now 43 identified deaf/blind children throughout the state - 11 in the BRS&H Program, 18 at MSDB (14 in the Title VI-C program and 4 in the regular school program), 10 in multi-handicapped programs in local educational programs and 4 in home-bound programs.

Coordination between all programmatic aspects has been assured through the supervision of a single coordinator of deaf/blind services--trained and experienced in the separate program components and who has been with the program since its inception.

The coordinator is also involved in parental counseling, and acts as an advocate in providing services needed for the children.

#### PROGRAM PHILOSOPHY

The various state agencies that influence the lives and development of deaf/blind children and the direct care and teaching staff are committed to--and believe in--all children's rights and dignity.

The severity of the multi-sensory handicaps requires a very special and inordinate awareness of the total needs of each child. The basic and fundamental need for love becomes the cornerstone for building the developmental skills which enable the child to function at his or her optimum level. The overall goal of the program is to maximize the potential of each child by the use of the best methods, materials and attitudes, beginning in life as soon as possible. We want each child to communicate with and adjust to the world around him or her, thereby promoting self-assurance and meaningful participation in society.

Service delivery systems for deaf/blind children are not restricted in imagination or innovation and, in fact, any new and effective mode of service delivery is encouraged by the Board of Public Education and the State Office of Public Instruction.

### PROGRAM PLANNING

The overall effectiveness and conduct of the education and training programs are good to excellent. The children receive consistent services, which are continually monitored and modified to meet their individual needs. There is, however, one element of program planning or need that is in the consciousness of many individuals working with these children. That element is: what will the needs of these children be when they reach an age at which it is not appropriate to continue the present training structures? And who is going to plan and provide for those service needs?

We have in Montana 6 children who will pass their 18th birthday within the next few years. We realize that the age of 18 is not necessarily a magical age of transition from one form of need to another, but sometime in the very near future, there will have to be a marked change in their environment and programming to meet their needs.

The direction in program emphasis will focus on continuity of educational programming, to assure readiness for interface with a planned continuum of extended services.

Transitional vocational programs and living arrangements outside of the supervision of program personnel will be explored and arranged for appropriate students.

The state Liaison/Coordinator is in practical contact and communication with those agencies serving an adult population. Some such agencies are: Division of Visual Services, Rehabilitative Services Division, Division of Developmental Disabilities, Helena Industries, Progress, Inc., and Easter Seal Society.





## MSDB PROGRAM

### Level I Classroom

In the Level I Deaf/Blind class there are 8 children ranging in age from 10-19. Of these 8 children, two are in wheelchairs, one can walk with assistance and the others are ambulatory. Six of the children live in group homes in the Great Falls community.

In this class the following areas are addressed: behavior control, visual, auditory and tactile; Kinesthetic stimulation, environmental, peer and self awareness; daily living skills; pre-language and communication skills; visual and auditory development; and motor development. These skills are taught in both individual and group situations. Total communication is always used with two of the children on an informal pre-language and communication (co-active) program. An adaptive PE class emphasizes vestibular stimulation, motor development and peer awareness. Handwashing, toothbrushing, and feeding skills are addressed at school. Bathing and dressing programs are run every morning in the group home by school staff; this is the first time they have gone into the group homes and the children, teachers and group home staff have benefited from this action. Since one of our main goals is to help the children become as independent as possible, these programs are essential. It has given the teachers a chance to see how the children function in their home environment.

Skill-wise, the progress had been significant with bathing and dressing; but in addition to that, the children are gaining in "self-awareness". As with other pilot projects, there have been some problems getting this new program started, but the benefits and progress speak for themselves. Aside from the programs run in the school and the group homes, the children, teachers, and aides are involved in an informal swimming program at an indoor pool in Great Falls once a week with the recreation director from the school.

The Callier Azusa Scale (done at the beginning and end of each year), Pre-Language and Communication Guide for the Multihandicapped and Sensory Stimulation Kit from the Printing House for the Blind are the basic materials used for assessing and programming. In the past, various vision assessments, etc., have been used. Individual Education Programs (IEPs) for each child are maintained and include quarterly reports throughout the school year. Parents are encouraged to attend the IEP meetings. (For more information about the IEP, see Section 8 of the Plan.)

### Level II Classroom

The children attend school in the deaf/blind classroom from September 4th to June 6th. There are 5 students, one teacher and one aide in the deaf/blind Level II Classroom - the age range is from 5 to 18. The philosophy of the classroom is based on two approaches: One involves an infant program and the other involves daily living skills and pre-vocational training. Emphasis in both approaches are in the areas of behavioral control and communication and cognitive skills.

The classroom is organized in a highly-structured manner, yet there is freedom, on occasion, for the students to choose any activity he or she desires.

The Callier-Azusa Scale is used to assess the students each year and the progress they have made is recorded on their IEP, which is located in their plan book. (A book that contains all relevant information concerning the student.) The resources of the classroom are as follows: the Pre-Language Curriculum Guide for the Multi-handicapped; a Cognitive Approach to Pre-Vocational and Daily Living Skills Training; Skill Tasks (Handbook of Pre-Vocational Activities); Language Acquisition Program for the Retarded or Multiply Impaired; Infant Stimulation Kit; and the Infant Curriculum.

Daily living skills are incorporated into the group home living environment. The dressing and bathing programs are executed at the appropriate time and one day a week a few of the students stay in the group home and work on cooking, cleaning and recreational activities. Daily living skills taught in the classroom include: washing hands, brushing teeth, cooking, eating and toileting.

Pre-vocational skills emphasize independent work skills for a period of one-half hour, using activities such as assembly work, packaging, sorting, matching, numbers, one-to-one correspondence, and folding.

The infant program emphasizes body awareness as well as visual, auditory, and sensory stimulating activities.

Various communication programs occur during the day. These programs range from the resonance level in co-active movement to understanding simple sights, plus language taught using a communication machine.

Behavioral controls are executed throughout the day and daily data is recorded in order to evaluate the effectiveness of the controls.

One student in the classroom receives physical therapy three times a week and another student receives inability instruction twice a week.

The afternoons are devoted to PE, art and music. Also, once a week the children have swimming and a trip to Mr. Donut.

Quarterly, we have evaluation reports. At this time, there is a conference scheduled between teachers, parents and group home parents. This is an excellent time to exchange information and share experiences.

## BOULDER RIVER SCHOOL AND HOSPITAL PROGRAM

The staff at BRS&H are presently serving 11 deaf/blind children. Of these children, 9 are severely and profoundly handicapped, orthopedically, and reside in the non-ambulatory section of the hospital; the 2 ambulatory clients reside in a newly-established, sensory-impaired cottage on grounds. Functioning levels of the children range from basic gross motor and self-help training (i.e., grasping, head control, passive eating, toileting schedules, hand-washing, sensory stimulation, reduction of tactile defensiveness, and developmental motor exercises) to early cognitive, manual communication, and independent living skills (i.e. object sorting, naming object, mobility, clothing care, hand-washing after toileting, and pre-vocational training). In some cases, serious maladaptive behaviors pose a threat to the safety of the children themselves and trainers, or disrupt the training situation. Approved Behavioral Intervention Programs have been developed by cottage staff and are utilized in the deaf/blind classroom.

Although the two ambulatory children are served in the actual "training" building on grounds, the remaining 9 are prohibited from the same service for several reasons, not the least of which is lack of transportation for non-ambulatory children. Because of this, and the health considerations of the children themselves, the teacher and aide travel to the hospital area, and work with the 9 children in training space provided in an attached wing.

### Program Development/Curriculum

This deaf/blind program is in a somewhat unique situation because of its placement within BRS&H. Not only does the program have to meet Title VI-C regulations, but it must operate within the general framework of the institution, complying with additional state and federal guidelines. For this reason, the assessment and program development procedures may vary from other Title VI-C programs.

Within the institution, all clients are scheduled for a comprehensive interdisciplinary evaluation once yearly. For the purposes of assessment, each client is seen by a representative of Habilitation (cottage), Recreation, Education, Physical Therapy, Occupational Therapy, Communication, Psychology, Social Work, Audiology, and special areas when applicable (i.e., Title I, Foster Grandparents, Religion). This staff comprises the Habilitation Planning Committee (HPC) under the direction of an Individual Habilitation Plan (IHP) Coordinator. Assessments are made using various standardized devices according to service areas and the clients level of functioning (i.e., Adaptive Behavior Scale, Camelot Behavioral Checklist, Preschool Attainment Record, Developmental Activities Screening Inventory, Peabody Developmental Motor Scales, etc.) In conjunction, the Collier-Azusa Scale is completed by the deaf/blind teacher on each child eligible for



Title VI-C services. After gathering results and other necessary information, the HPC meets to discuss evaluation results and make recommendations for priority training. It is from these recommendations that all programming, including Title VI-C, is developed and recorded in an Individual Habilitation Plan.

Specific to the Title VI-C program, A Cognitive Approach to Pre-Vocational and Daily Living Skills is utilized, when appropriate, for the two higher functioning children.

SERVICES PROVIDED

TABLE 3.A

ALTERNATIVE COMMUNITY LIVING SERVICES

Agency: State Board of Education  
Program: Deaf/Blind Programs

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
MSD&B		X		X		X	X	X
Homebound	X	X				X		X
Group Homes		X		X		X	X	X
Local Ed. Programs		X				X		X

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TABLE 3.A

CASE MANAGEMENT SERVICES

Agency: State Board of Education  
Program: Deaf/Blind Programs

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
BRS&H	X	X	X	X	X	X	
MSD&B	X	X	X	X	X	X	
Local Ed. Programs	X	X	X	X	X	X	
Homebound	X	X	X	X	X	X	
Group Homes	X	X	X	X	X	X	



SERVICES PROVIDED

TABLE 3.A

Agency: St. Board of Education  
Program: DEAF/BLIND PROGRAMS

CHILD DEVELOPMENT SERVICES

Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Counseling/Training of Parents	Prevention
BRS&H	X	X	X	X		
MSD&B	X	X	X	X		
Group Homes	X	X				
Homebound	X	X			X	
Local Ed. Programs	X	X		X		

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TABLE 3.A

Agency: State Board of Ed.  
Program: Deaf/Blind Programs

NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/Day Activities
BRS&H	X			X	X	X
MSD&B	X	X		X	X	X
Local Ed. Programs	X			X	X	
Home Bound	X			X	X	
Group Homes	X	X		X	X	

NUMBERS OF PERSONS SERVED

ALTERNATIVE COMMUNITY LIVING

Deaf/Blind Programs

Table 3. B

REGION	In-House Services		CAPACITY FOR MORE			Family Support		CAPACITY FOR MORE			Group Living		CAPACITY FOR MORE			Staff Training		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
BRS&H																				
MSD&B						18	18				18	18				18	18	X		
Local Ed. Prg.						10	10									10	10	X		
Home-bound Group Homes	4	4				4	4									4	4	X		
						12	12				12	12				12	12	X		

Constraints: 1. Lack of training for local education programs  
2. Termination of 6C funding after 1980.

Table 3. B

ALTERNATIVE COMMUNITY LIVING - DEAF/BLIND

REGION	Placement		CAPACITY FOR MORE			Maintenance		CAPACITY FOR MORE			Group Living		CAPACITY FOR MORE			Staff Training		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
BRS&H																				
MSD&B	18	18				18	18													
Local Ed. Prg.						10	10													
Home-bound Group Homes						4	4													
	12	12				12	12													

# NUMBERS OF PERSONS SERVED

## CASE MANAGEMENT

## Deaf, Blind Programs

Table 3. B

REGION	Assisting with Access		CAPACITY FOR MORE			Consultation with Family or Client			Coordination of Services			CAPACITY FOR MORE			Support Services			CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
BRS&H	11	11				11	11				11	11				11	11			
MSD&B	18	18				18	18				18	18				18	18			
LOCAL																				
Ed. Prg.	10	10				10	10				10	10				10	10			
HOME-BOUND	4	4				4	4				4	4				4	4			
GROUP HOMES	12	12				12	12				12	12				12	12			

Constraints to services: 1) Loss of 6C funding after 1980 affects all PSAs  
 2) Lack of year-round school  
 3) Lack of P.T./O.T. services

## CASE MANAGEMENT DEAF/BLIND

Table 3. B

	Follow Along		CAPACITY FOR MORE			Monitoring of Client Progress			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
REGION	11	11				11	11													
BRS&H	18	18				18	18													
MSD&B	10	10				10	10													
Local																				
Ed. Prd.	4	4				4	4													
Home-bound	12	12				12	12													
Group Homes																				

## NUMBERS OF PERSONS SERVED

Deaf/Blind Programs

[illegible]

Figures represent duplicate services

-78-

Contraints to services:

- 1) Lack of P.T./O.T. services
- 2) Lack of year-round school
- 3) 6C funding terminates 1980

Table 3. B

[illegible]



## NUMBERS OF PERSONS SERVED

Table 3. B  
ADVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES  
Deaf/Blind Programs

REGION	Daily Living			CAPACITY FOR MORE			Transportation			CAPACITY FOR MORE			Recreation		CAPACITY FOR MORE			Training in Personal/Social/Civic			CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT			
BRE&H	11	11															11	11					
MD&B	18	18				18	18										18	18					
Local Ed. Prq.	10	10									10	10					10	10					
Home-bound	4	4									4	4					4	4					
Group Homes	12	12				12	12										12	12					

-79-

Constraints to services: Termination of 6C funding after 1980

Table 3. B  
NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES - DEAF, BLIND[illegible]



Section 3

DEVELOPMENTAL DISABILITIES DIVISION



## DEVELOPMENTAL DISABILITIES DIVISION

The Developmental Disabilities Division is the unit within the State Department of Social & Rehabilitation Services which is primarily responsible for providing community-based services to developmentally disabled individuals. The organizational structure of the Division is indicated on the Table on the next page. The Division was formed in 1976. From 1974 to 1976, community DD services were provided through a bureau within the Rehabilitative Services Division of the department. Prior to that time, community-based services for the DD were administered through the Department of Institutions by Boulder River School and Hospital. Key legislation was passed in 1974, with substantially increased funding appropriated in 1975, for development of community-based services in conjunction with a deinstitutionalization effort.

The DDD had a FY 1980 total budget of over \$9 million. Approximately 50% of these funds were supplied from the Montana State General Fund, and the remainder from Federal sources including Title XX, Title XIX, and P.L. 95-602.

In FY 1980, the Division spent roughly 88% of its total budget on direct client services and 12% on Division and Regional Council operating expenses. In FY 1981, the funds will be distributed in the approximate percentage as in 1980, with a 5.5% increase over FY 80, among the direct services and operating functions.

All persons who are determined DD, as defined by state law (53-20-202, MCA 1979), are eligible for services. With the exception of family training and support services, for which the provider determines eligibility, all other eligibility for services is determined through the county social services system. Although there is no financial eligibility requirement, this information may be gathered for administrative fiscal purposes.

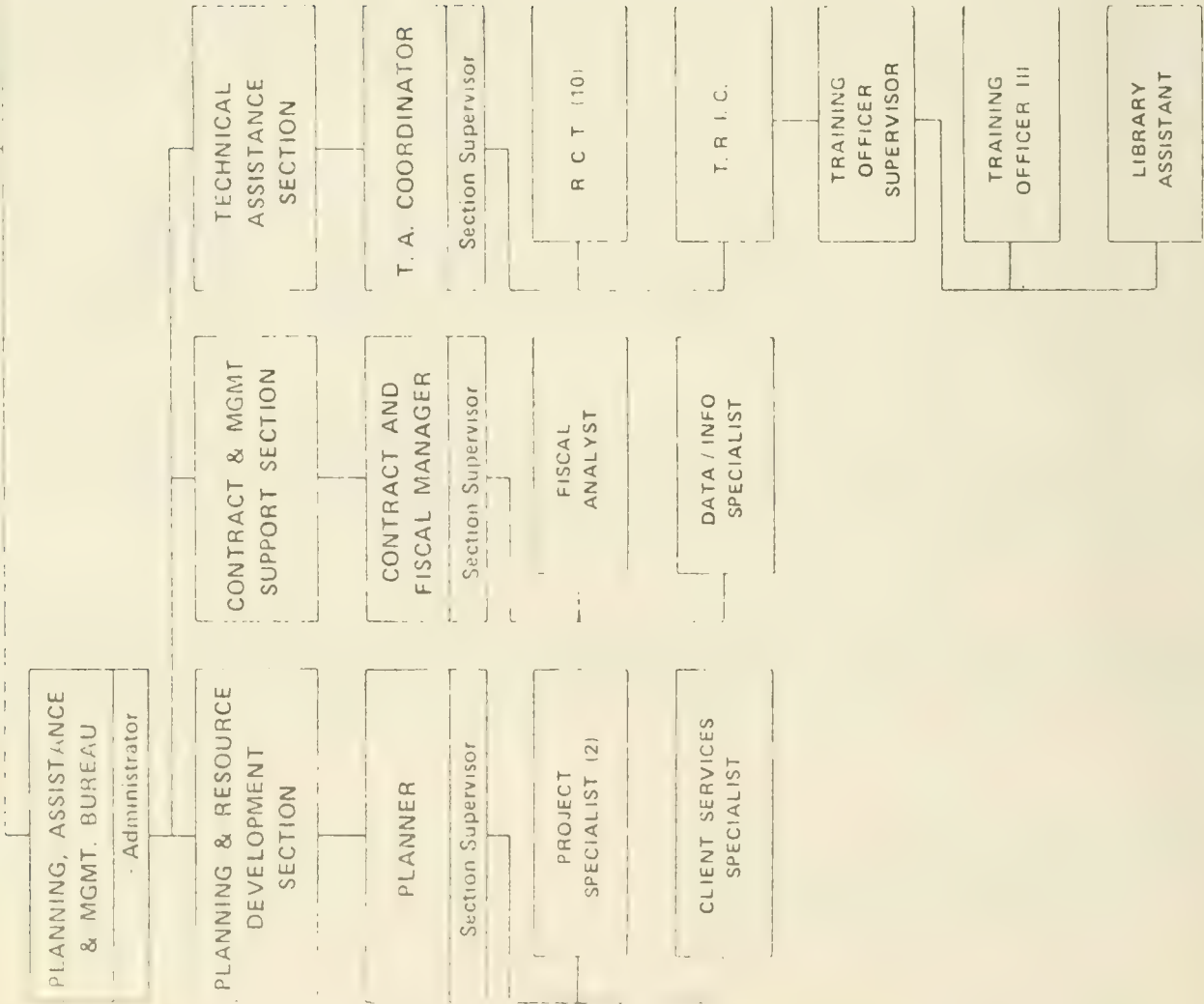
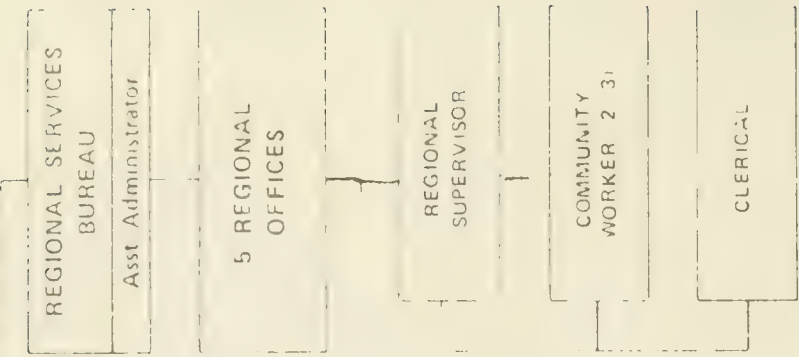
The DDD does not provide most services directly. Two exceptions to this are case management, which is provided for a short time for persons leaving the institution, and staff training. The Division uses a purchase of service contract system for the provision of services through local agencies and organizations.

In January, 1980, approximately 1,600 persons were receiving services through local agencies funded by the Division. These services consist of five major areas including day, residential, and transportation services, family training and support, and diagnosis and evaluation.

### Service Descriptions

For contract purposes, the Division describes the above services in the following manner:

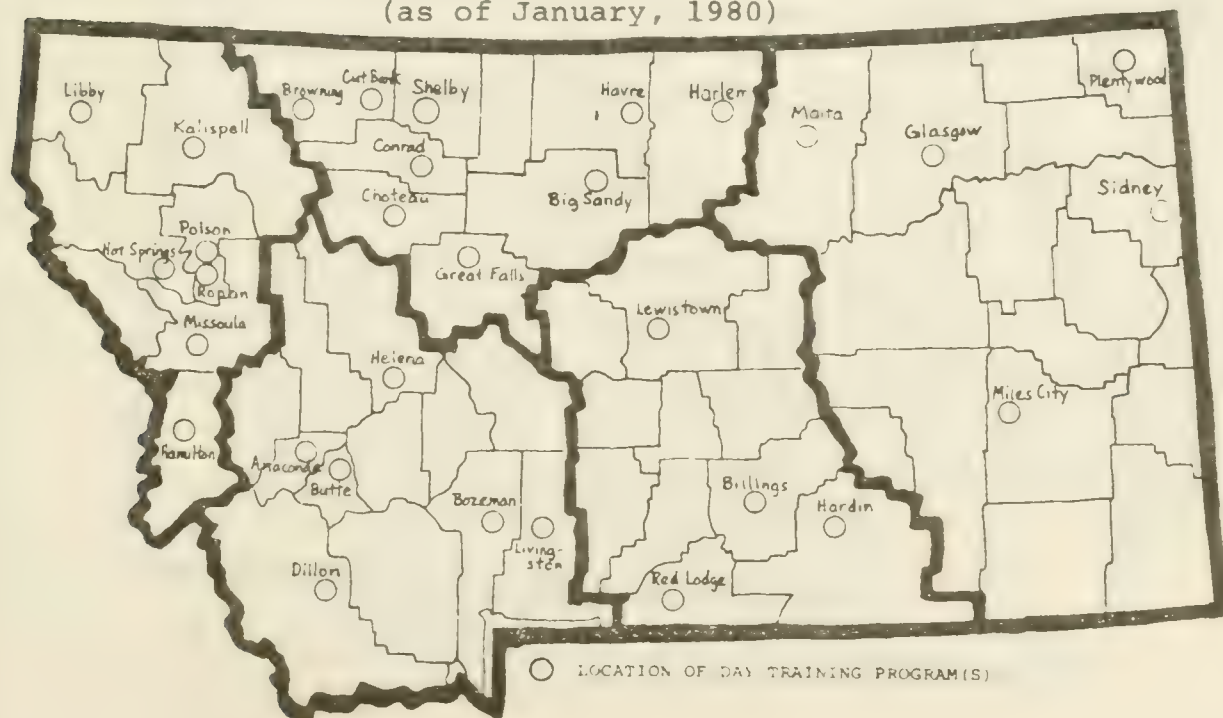
DEVELOPMENTAL  
DISABILITIES  
DIVISION  
Administrator



- I. ADULT DAY SERVICE: Adult day services provide a supervised, habilitative training situation for DD adults including pre-vocational, work activity or vocational sheltered employment training. The major goal of day services is to provide instruction and intervention under a developmental model and in accordance with the principle of normalization, all of which is directed toward individual movement to a higher level of independence. These three areas are further described as:
- A. Pre-vocational Training: Training in basic skill areas which are pre-requisite to the client advancing to a paid work setting and achieving greater independence.
  - B. Work Activity Training: A combination of training in basic skill areas and work skills through paid work. The facility in which training occurs must be certified by the Department of Labor as a "Work Activity Center", which requires a group wage of 1% to 25% of the minimum wage being paid clients.
  - C. Vocational Sheltered Employment: Training which provides habilitation/rehabilitation services involving the utilization of individual goals and a controlled work environment to help DD persons achieve and maintain their maximum potential as workers. The facility in which training occurs must be certified by the Department of Labor as a "Sheltered Workshop."

The locations of Division funded day services are shown in the map below.

LOCATIONS OF DAY PROGRAMS  
(as of January, 1980)

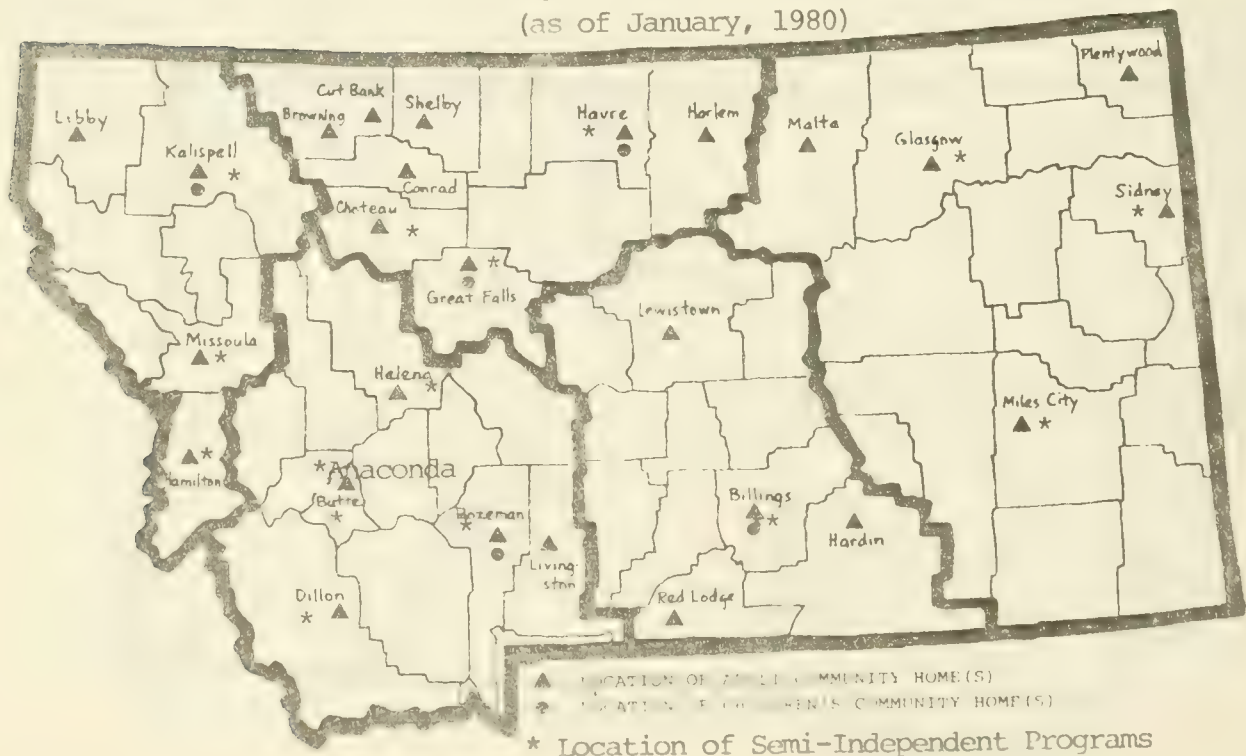




II. RESIDENTIAL SERVICES: Residential Services are provided to DD individuals in the environment in which they reside and include varying degrees of training and supervision. The DDD purchased services in three residential components: children's community homes, adult community homes, and semi-independent living and training services. The major goal of residential services is to provide instruction and intervention under a developmental model and in accordance with the principle of normalization, all of which is directed toward maximum skill acquisition in order to increase personal independence. These three areas are further described as:

- A. Children's Community Home: A licensed alternative living arrangement which provides a supervised living situation with board and room and training for children who have severe or profound mental retardation or another severe multiply handicapping developmental disability.
- B. Adult Community Home: A licensed alternative living arrangement which provides supervision, room and board, and training to adults with DD.
- C. Semi-Independent Living and Training: A service by outreach trainers to assist individuals with DD age 18 years and over who have achieved designated skills for semi-independent living. The clients may live in a variety of residences with varying degrees of supervision and training specified by the IHP team and the client.

LOCATIONS OF COMMUNITY HOMES  
AND SEMI-INDEPENDENT PROGRAMS  
(as of January, 1980)



Residential services include client training, service coordination, support and follow along services.

1. Service Coordination: Outreach trainers assist regional and/or social services staff to locate, develop and coordinate generic services in the community to support individuals enrolled in the semi-independent living and training service. Such assistance may include:
  - a. providing information, training or planning programs in conjunction with other agencies or organizations which assist in serving an individual;
  - b. assisting in the development of services;
  - c. providing professional interagency intervention to promote the interests and fulfill the needs of the individual;
  - d. locating and providing resources for individuals; e.g., medical and dental services, locating a new residence and assisting an individual in moving to that setting (excluding training related movement); and
  - e. making parental contacts after consultation with the social worker.
2. Support Services: Outreach trainers will assist in all areas of development and sustaining of each individual.

Individual support is the responsibility associated with individual training programs. This responsibility includes:

- a. preparing IPPs which correspond to IHP short-term goals;
- b. preparing task analyses when applicable;
- c. collecting pre-test/baseline/initial probe data prior to IPP implementation;
- d. recording and graphing data;
- e. modifying IPP components when necessary;
- f. including accelerated behavior for each decelerated behavior;
- g. stating, in specific measurable terms, goals related to the training provided;
- h. documenting needs not addressed;
- i. all record-keeping duties;

- j. monthly review of IHP and IPP;
- k. coordinating IHP with other service agencies; and
- l. attending IHP meetings.

Staff support services include staff meeting, staff training and other staff duties.

- 3. Follow Along: Minimal services for not more than two hours monthly will be provided by outreach trainers upon the request of clients who have graduated from semi-independent living and training services and who live independently. These services may include any of the service component areas.

III. TRANSPORTATION: Transportation services are for the purpose of conveying DD persons from a residential setting to a work setting and back or from a residential or work setting to another site at which they receive services.

LOCATIONS OF TRANSPORTATION PROVIDERS



IV. FAMILY AND CHILDREN SERVICES: Services to families and children are the provision of training, information, and support services to families to assist in the development and care of their child who is either DD or at risk. These services are coordinated with other generic and specialized community services.

A. Family Training and Resource Services for Natural or Foster Families:

1. Family Training: The major goal of Family Training is to assist the natural or foster family in maximizing the developmental potential of its child. The optimal method of achieving this goal is through family focused training.
  - a. Family Focused Training: The goal of Family Focused Training is to train family members to become the primary intervention agents for their DD child in order that they may design and conduct developmental and/or behavioral programs, advocate effectively for their child, and fully utilize appropriate community services. Staff will assist family members in developing their own skills which may include, but are not limited to, knowledge of the child's handicapping condition; normal patterns of development; designing and implementing developmental and/or behavioral programs; and developing an awareness of and utilization of generic and specialized community services. The intent of Family Focused Training is to assist family members to function as independently as possible in providing or obtaining needed services for their child in order that the assistance of family services staff can be phased down or out.
  - b. Child Focused Training: In Child Focused Training, family services staff trains family members to conduct specific skill acquisition or behavioral intervention programs with their child. The primary objective is to teach the child new skills or alter the child's behavior. The family services staff conducts assessments; develops the programs; trains the family to implement the program; monitors the family's activities; and evaluates the effectiveness of the programs. The staff maintains regular contact with the family as objectives are met and new programs are needed.



2. Client Training: Client Training is direct training by family services staff with an individual living in a natural or foster home for the purpose of skill acquisition or behavioral intervention. This includes short-term, intensive efforts and long-term, on-going efforts. Major training responsibility is not shared by the parent or family members. The goal is for the child to gain skills or to decrease the level of inappropriate behavior. Short-term efforts are those that terminate upon completion of a specific objective, such as learning a skill or the elimination of an undesired behavior. The purpose of this training may be to demonstrate the effectiveness of the method, to begin shaping the child's behavior until the family thinks it can intervene, or to support the family by meeting one specific need which the family feels essential. Long-term efforts are those that are provided on an on-going basis. The agreement with the family for provision of this service would primarily be based on time. Within this designated time, specific programs would be developed implemented and completed. As programs are completed, new programs would be developed. The family services staff would be involved in regular, frequent contact with the child.
3. Family Resource and Support: Family Resource and Support are services provided by family services staff directly to a family or their child to assist in the development and maintenance of the family unit and/or the child. These services are individualized according to family needs and may include, but are not limited to, the provision of transportation; educational information, adaptive equipment and training materials other than those directly related to a formal training program; family group sessions for purposes other than direct training; and social-emotional support, including limited counseling.
4. Family Service Coordination: These are services provided by working with other agencies on behalf of the family or child. The goal is to assist the family in obtaining all the necessary and appropriate services and promote coordination of these services. This may include, but is not limited to, the provision of information, training or program planning with specific agencies providing services to the individual; the development or initiation of needed services; or intervening for the family or child to promote their interests or needs. The contacts with the agencies are specifically related to an individual client as opposed to general agency contacts.



5. Information and Referral: Information and Referral is the provision of a service by family services staff which directs families not currently on the caseload to the most appropriate available services to meet their needs. It may involve determining the families' needs; investigating availability and appropriateness of various services; explaining the options to the family; and contracting the agencies on behalf of the family. The appropriate service may or may not be Family and Children Services. In the latter case, it will involve facilitation of referral to another more appropriate agency.

Another service under this category may be the provision of any information requested by families who have previously been on the Family and Children Services caseload to whom services have been discontinued. This information may or may not be related to agency referrals.

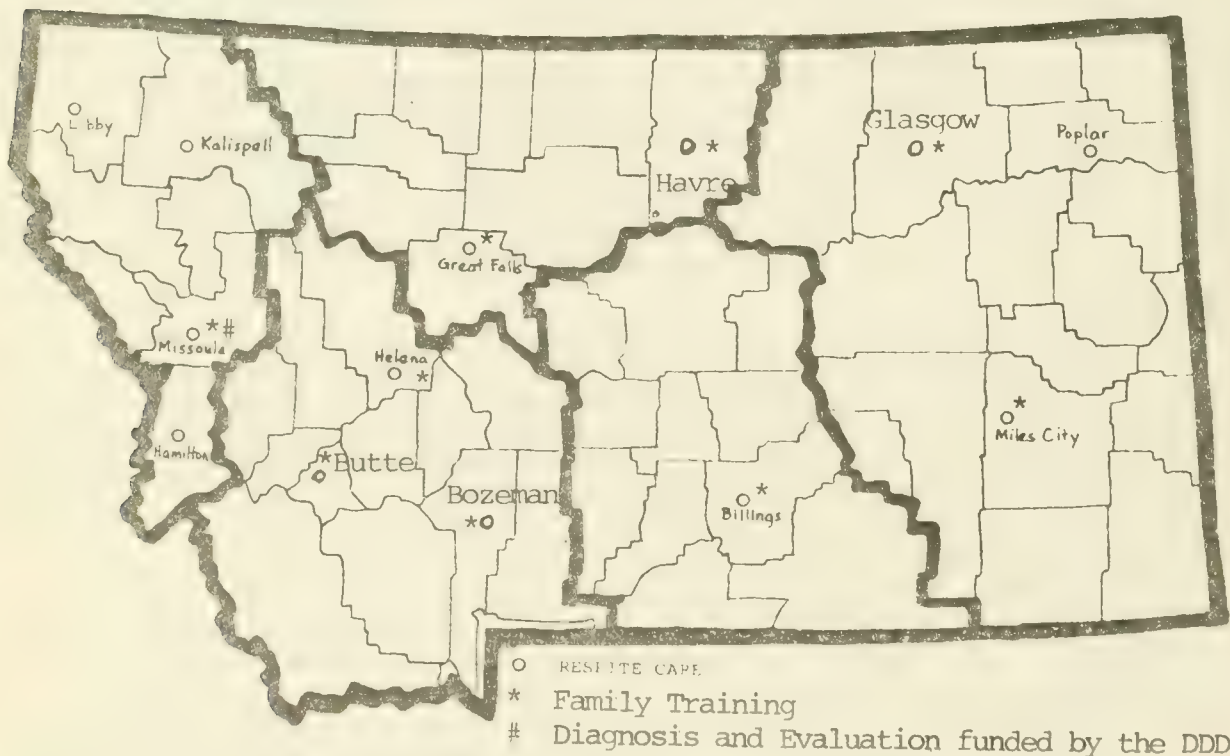
- B. Definition for "At Risk": "At Risk" means a child who is between birth and five years of age who may become developmentally delayed or DD due to:
- a. Established Risk: an infant whose early appearing aberrant development is related to diagnosed medical disorders of known etiology bearing relatively well-known expectancies for developmental outcome within specified developmental delay (e.g., Down's Syndrome);
  - b. Environmental Risk: a biologically sound infant for whom life experiences including maternal and family care, health care, opportunities for expression of adaptive behaviors, and patterns of physical and social stimulation are sufficiently limiting to the extent that, without corrective intervention, they impart high probability for developmental delay; or
  - c. Biological Risk: infant presenting a history of prenatal, perinatal, neonatal, or early development events suggestive of biological insults to the developing central nervous system and which, either singly or collectively, increase the probability of later appearing aberrant development.
- C. Other Services:
- 1. Evaluation and Diagnosis: The provision of clinical inter-disciplinary services designed to assess the level of development in terms of capability as well as deficiencies. The major purpose of Evaluation and Diagnosis Services is to identify areas of needed services and programs relevant to clients' capabilities and deficiencies.

(See the subsection of Section 3 pertaining specifically to Diagnosis and Evaluation Services in the State. That subsection describes all three Montana D&E programs in detail.)

2. Respite Services: Respite care and training includes in-home and out-of-home care of developmentally disabled persons by trained individuals. Services are provided for a short, fixed period of time in order for natural or foster parents to provide relief from the continual care of their family member.

Family and Children Services are available statewide, with main and branch offices located throughout the state.

LOCATIONS OF  
FAMILY TRAINING AND SUPPORT AND DIAGNOSIS AND EVALUATION SERVICES  
(as of January, 1980)



The total number of individuals receiving services in each program detailed above is indicated in the following table.

Total Number of Individuals Receiving Services Through the DDD in December, 1979:

<u>Program</u>	<u>Number</u>
Day Services	930
Residential Services	
Adult Community Home	365
Children's Community Home	35
Semi-Independent	135
Transportation Services	830
Family and Children Services	415
Respite Care	<u>350</u>
Total Unduplicated Count	1620

INDIVIDUAL HABILITATION PLANS

Montana state law (53-20-203, M.C.A., 1979) requires that each client in Montana's community based DD system must have an Individualized Habilitation Plan (IHP) within 30 days of the client's entry into a program. The IHP is an evolving written plan which states, in long and short term goals, how the needs of an individual will be addressed, the names of persons and programs responsible and the specific time frames involved. The IHP is usually developed by an Individual Habilitation Planning Team consisting of the client, the client's advocate, the casemanager, at least one person from each service program in which the client participates, a representative from the institution from which the client has not been formally discharged, if appropriate, and one person from the DDD.

The person or program designated as responsible for each short term goal must develop an Individualized Program Plan (IPP) which specifies a behavioral objective, the methods to be used to accomplish that objective, and the procedures to be used to measure the client's progress. Program plans are developed after the habilitation planning meeting.

For further information about the Division's IHP procedures, see Section 8 of the plan.

## QUALITY OF SERVICES

Evaluation of programs consist of on-site visits and contract reviews conducted by staff of the DDD. An evaluation system is being developed jointly by the state and regional DD advisory councils, service agencies, and the DDD.

Additionally, regional councils are actively involved in the evaluation of services. Each council has developed its own on-site evaluation procedure. The councils also make annual recommendations to the Division regarding service provider contracts.

For information about the Division's Technical Assistance Section (training), see Section 6 of the plan.

Goals and Objectives for 1981, 1982 and 1983: (Funding for FY 82 and FY 83 is dependent upon legislative action).

1. To maintain current level, as of June 30, 1980, community-based residential services for a projection of 50 children and 540 adults.
2. To provide current level, as of June 30, 1980, prevocational and vocational training for a projection of 960 adults.
3. To maintain current level, as of June 30, 1980, for a projection of 600 families and children in family training and support services.
4. To provide, at current level, evaluation, diagnostic and support services for at least 100 children and adults.
5. To provide current level, as of June 30, 1980, transportation for a projection of 840 persons.
6. To manage and support a statewide community-based service delivery system utilizing a regional structure.



TABLE 3.A

## SERVICES PROVIDED

## ALTERNATIVE COMMUNITY LIVING SERVICES

Agency: SPS  
Program: LDC

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
Residential Services	X		X	X		X	X	X
Respite Care	X	X	X		X	X	X	X

TABLE 3.A

## CASE MANAGEMENT SERVICES

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
Functional Day Training	X	X	X	X	X	X	X
Residential Services	X	X	X	X	X	X	X
Early Intervention	X	X	X	X	X	X	X
Family & Child Training	X	X	X	X	X	X	X

TABLE 3.A

## NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/Day Activities
Functional Day Training	X	X			X	X
Residential Services	X	X			X	
Transportation	X	X			X	X

TABLE 3.A

## CHILD DEVELOPMENT SERVICES

Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
Residential Services					X	X
Family & Child Training	X	X	X	X	X	X



## NUMBER OF PERSONS SERVED :

ADITYA: SIS  
PROGRAM: DDD

# ALTERNATIVE COMMUNITY LIVING ARRANGEMENTS

Region	In-house Services			CAPACITY FOR MORE			Family Support			CAPACITY FOR MORE			Foster Care			CAPACITY FOR MORE			Group Living			CAPACITY FOR MORE		
	TOTAL	a)		YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT			
		DD	52																					
1	52	52					44	44				N/A					37	37						
2	147	147					61	61				N/A					132	132						
3	104	104					62	62				N/A					66	66						
4	138	138					110	110				N/A					94	94						
5	90	90					74	74				N/A					70	70						

a. "Developmentally disabled" according to state law  
b. See page at end of Tables 3.B for constraints to services

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## ALTERNATIVE COMMUNITY LIVING ARRANGEMENTS (CONT.)

[illegible]

Table 3.3 (Cont'd)

## CHILD DEVELOPMENT SERVICES

REGION	Early Intervention		CAPACITY FOR MORE		Counseling of Parents		CAPACITY FOR MORE		Training of Parents		CAPACITY FOR MORE		CAPACITY FOR MORE			
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	
I	41	41				65	65				65	65				
II	38	38				89	89				89	89				
III	49	49				62	62				62	62				
IV	43	43				142	142				142	142				
V	41	41				58	58				58	58				

Table 3.5

## CASE MANAGEMENT

REGION	Assisting with Access		CAPACITY FOR MORE			Follow Along		CAPACITY FOR MORE			Coordination of Services			CAPACITY FOR MORE			Other Services		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	
I	117	117				168	168				233	233					351	351			
II	236	236				380	380				469	469					670	670			
III	246	246				259	259				249	249					402	402			
IV	280	280				342	342				484	484					350	350			
V	148	148				309	309				367	367					403	403			

# NUMBERS OF PERSONS SERVED

Table 3.3 (Cont'd)

## NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES

	Assisting with Daily Activity		CAPACITY FOR MORE		Work Activity		CAPACITY FOR MORE		Other Services		CAPACITY FOR MORE		CAPACITY FOR MORE	
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO
1	168	168				116	116				246	246		
2	380	380				233	233				380	380		
3	259	259				155	155				307	307		
4	342	342				204	204				361	361		
5	309	309				219	219				355	355		

The following constraints to services apply to all priority service areas unless otherwise specified:

1. Insufficient funds to provide services to all individuals, causing long periods of time in which persons do not receive any services.
2. Major areas missing in the service continuum which results in poorer quality services and lower rates of growth of individuals and movement between services, i.e., semi-independent services; intensive training; residential services; services for children who have severe physical care needs in addition to training needs; statewide diagnostic and evaluation service; prevention program; etc.
3. Inability to effectively assure quality of services or monitor services provided.
4. Lack of funds.
5. Weakness in administration of program at all levels.
6. The need to develop an effective purchase of service contract with appropriate monitoring.
7. The need to develop, implement and maintain nationally-recognized standards for all programs.
8. The need to determine long range goals (5-10 years) with each involved agency from a statewide perspective.
9. The need to implement more effective administrative procedures at all levels, including fiscal and program management information; contracting procedures; program evaluation; and research.





### Section 3

#### DIAGNOSIS & EVALUATION PROGRAMS



## MONTANA CENTER FOR HANDICAPPED CHILDREN

### History and Administration

The MONTANA CENTER FOR HANDICAPPED CHILDREN (MCHC) was established in 1947 as the CEREBRAL PALSY CENTER. Services were offered only to children with Cerebral Palsy in a five county area and included speech therapy and physical therapy. Support was from a small federal grant, local funds, State Board of Health, and Eastern Montana Normal School.

Services were gradually offered to additional counties and included a school program and occupational therapy. In 1955, services were offered to all of the state for all physically or multi-handicapped children.

The CENTER is administered by a Board representing the three sponsoring agencies.

In November, 1972, the Center moved into a specially designed area in the Special Education Building after operating for twenty-five years in the basement of McMullen Hall on the campus of Eastern Montana College.

### Purposes

- 1) To provide diagnostic and evaluation services for physically, medically, orthopedically, mentally, speech and hearing handicapped or multihandicapped children.
- 2) To provide a specialized, structured, individualized, modified, academic school program for handicapped children.
- 3) To provide speech, physical, occupational and adjustment therapy for these children.
- 4) To provide special training opportunities for college level students with observation, participation, internships, affiliations and practice teaching stations.
- 5) To provide counseling and support to parents of children in the Center School program.
- 6) To provide counseling and consultation regarding handicapped children to parents and teachers of handicapped children in other schools and programs through the "Outreach" program.
- 7) To provide screening and limited direct therapy for children in other schools and programs, including supervision of home therapy programs through the "Outreach" program.

## Services Provided

- 1) School: (Four classes) for Orthopedically and Multihandicapped children
- 2) Therapies as required:  
Physical Therapy  
Occupational Therapy  
Speech Therapy  
Adjustment Therapy
- 3) Clinical Diagnostic and Evaluation Service:  
Medical Clinics (Primarily Orthopedic)  
Myelodysplasia Clinics (Spina Bifida)  
Mental Retardation Evaluation Clinics  
Speech and Hearing Clinics  
Cleft Palate Clinics
- 4) College Training: Teaching college classes, Visiting Lecturers, Training Student Teachers, Interns, Affiliates and Trainees
- 5) "Outreach": Special Consultation Service for parents, teachers and others regarding physical disabilities, therapy programs, nutrition, behavior and adjustment

## Clinical Program

A cooperative, coordinated team approach characterizes the Center program and is especially important in the Clinical Program. Children (birth to 21 years) seen in the clinics are evaluated and examined by selected staff members and medical personnel; then during the staffing, the participants exchange information they have secured and develop the recommendations for treatment, medical procedures, therapy and education as appropriate. These staff recommendations are then presented to the parents for their consideration.

Medical Clinics, Mental Retardation Evaluation Clinics and Myelodysplasia Clinics are conducted over a two-day period with the staff evaluations during the first day and the staffing and parent counseling on the following day.

Laboratory tests, x-rays and consultations with other medical specialists are available in the local clinics and hospitals.

Referrals: Children may be referred to any of the clinics conducted in the Center from any source. A medical referral is required for all clinics except Speech and Hearing Clinics.

Foster Homes: Children enrolled in the school who live outside the Billings area may be placed in foster homes if required. Assistance in foster home placement is provided by the Yellowstone County Department of Public Welfare.

Medical Evaluation Clinic: Frequency: Two per month except July and August. Patients Seen: Eight per clinic. Staff: Pediatrician, Orthopedist, Public Health Nurse, Social Worker, Psychologist, Physical and Occupational Therapist, Speech Pathologist, Audiologist and Nutritionist. Representatives of other agencies are also included in all clinics as appropriate, including: Public Schools, Welfare Department, Vocational Rehabilitation, Public Health, Mental Health and Indian Health Service.

Myelodysplasia Clinic: Frequency: Three per year. Patients Seen: Eight per clinic. Staff: Pediatrician, Orthopedist, Urologist, Public Health Nurse, Social Worker, Physical and Occupational Therapists, Psychologist, Speech Pathologist, Audiologist and Nutritionist. (Neurologist Consultant).

Developmental Assessment Clinic: Frequency: Six per year. Patients Seen: Four per clinic. Special Limitation: Age (Maximum for initial evaluation) 5 years, 8 months. Staff: Pediatrician, Public Health Nurse, Social Worker, Psychologist, Speech Pathologist, Occupational Therapist, Nutritionist and Audiologist.

Speech Clinic: Frequency: One each week. Patients Seen: One or two per week. Staff: Speech Pathologist, Psychologist, Public Health Nurse and Audiologist.

Cleft Palate Clinic: Scheduled in September, October, November, March, April, and May. Patients Seen: Eight per clinic. Staff: Otolaryngologist, Pediatrician, Plastic Surgeon, Prosthodontist, Orthodontist, Social Worker, PHN, Nutritionist, Speech Pathologist, Psychologist and Audiologist.

#### Special Education Classes (School)

The Center provides a specialized, structured individualized, modified academic school program for handicapped children, 3 to 14 years of age.

Pre-School: Three and four-year-old children are provided a pre-academic training program and appropriate therapies.

Kindergarten: Special readiness training, language development and therapies.

Primary: Adjusted readiness, language development and academic program with appropriate therapies.

Intermediate: Individualized academic training with tutoring and appropriate therapies.

A time-limited diagnostic and evaluation program is provided for children to determine developmental levels, special abilities, need for therapies and special training or education programs. They are placed in a classroom during this evaluation period and provided a program of therapy and training developed cooperatively by all the therapies and the teacher.



## Outreach

A program of consultation and special assistance is provided to parents and school personnel working with handicapped children by an Occupational and Physical Therapist, a Social Worker, a Psychologist and a Nutritionist. Direct therapy for children may be available on a limited basis.

## Hearing Conservation Program

An Audiologist with the State Department of Health and Environmental Sciences provides audiological services including: complete audiological evaluations, hearing consultation, hearing aid fitting, aural rehabilitation and other audiological services for children and adults.

## WESTERN MONTANA COMPREHENSIVE DEVELOPMENT CENTER (CDC)

CDC, located in Missoula, is a non-profit corporation and receives funding through contracts with the DD Division of the Department of SRS, the MCH Bureau of the SDHES, county monies from six counties in Region V of the state, as well as fees from private persons and agencies. The Board of Directors is composed of one commissioner from the six participating counties. CDC provides evaluation and diagnostic services and family services.

The Evaluation and Diagnostic Unit (E & D) of CDC provides comprehensive transdisciplinary evaluations and case coordination for a variety of children and adults in Western Montana and other parts of the state.

The E & D Unit employs licensed or certified professionals from the disciplines of medicine, psychology, speech pathology and audiology, social work, nursing, nutrition, special education, physical and occupational therapy. CDC also has the capability to refer for EEG and brain scan procedures. When necessary, CDC utilizes other professionals such as orthopedists, eye, ear, nose and throat specialists, and neurologists in its evaluation process.

The CDC evaluation and diagnostic service is relevant because it confirms the existence of handicapping condition(s); the nature and severity of these conditions; and, most importantly, develops recommendations for programs and services to assist the handicapped individual and his family.

CDC has as its target population: children and adults who are at risk for DD, or who are DD. Developmental disabilities include epilepsy, cerebral palsy, mental retardation and autism, plus other conditions related to problems of intellectual functioning or adaptive behavior.\* CDC can also, upon specific request and agreement, provide E & D services for other types of exceptionalities.

The E & D Unit of CDC provides service through its centers at Missoula and Kalispell and also can provide on-site evaluations upon request.

The method of evaluation is best described as "transdisciplinary", that is, E & D members share responsibilities of assessment through joint observation and data sharing. An individual is not typically "segmented" by individual assessments. For example, the professional staff may utilize a single set of behaviors relevant to a client's psychological, linguistic, physical or educational needs.

The result is an integrated and unified evaluation of the client which considers various viewpoints but retains a view of a person, not artificially separated dimensions.

A unique feature of the CDC evaluation in the case of children is the inclusion of parents in the process through direct observation and participation in the testing. All information generated is shared through written reports, verbal interpretation and continuous follow-up.

As part of the E & D services, CDC clinical staff consult with agencies and parents on how to implement the recommendations contained in the report on evaluation. This insures translation of suggestions and recommendations into actions and change on behalf of a client. Each individual also has a casemanager assigned to insure that before, during, and after the evaluation, all CDC resources and those of all other relevant agencies are coordinated to provide maximum assistance.

Aside from complete and partial evaluations, CDC consults with staff of various agencies on meeting the needs of individual clients. This may include client assessments and identification of appropriate materials, techniques, and therapeutic strategies.

CDC also sponsors special clinics in which the E & D team works with medical and other health specialists both from within and outside Montana on topical areas such as cleft palate, genetic screening and counseling, and scoliosis. These clinics are held periodically on a regular basis.

Referrals to CDC can be made by parents, social workers, private professionals, medical personnel, and other human service agencies.

Family Services is a home-based teaching program for parents and their handicapped children. The purpose is: 1) to show parents how to teach their children specific skills; and 2) to teach parents to be more effective teachers.

The program takes place in the family's home on a regular schedule (weekly or bi-weekly). During the visit, the "home trainer" (CDC staff) discusses teaching methods with the parents and demonstrates how to do specific activities with the child. Then, while the home

trainer is still present, the parent and child practice the activity so that the parent has a chance to ask questions and become familiar with the activity before teaching it to the child by herself/himself. Between visits with the home trainer, the parent practices the activities with the child daily.

The parent can teach many different kinds of skills to the child. Examples include:

- Gross motor development (use of large muscles);
- Fine motor development (use of hands and arms);
- Self-help skills (use of hands and arms);
- Language development (skills which allow the child to independently care for himself);
- Cognitive or intellectual development (problem solving or "thinking" skills); and
- Social development

People can learn many new skills to help them become more effective teachers. They learn how to break activities down into small steps before teaching them to their child, how to provide attention and rewards when their child performs the activity correctly, how to provide assistance if the child needs additional help, how to provide appropriate instructions and how to monitor (keep track of) their child's progress. Parents also learn information about child development, how to manage their child's behavior and other resources/programs in their area.

Other staff members (case coordinators) assist the family in accessing additional services and assist the family in obtaining information in which they are interested. For example, the case coordinator might assist the family to apply for Supplemental Security Income benefits.

Families are eligible for the program if:

- 1) they have a child between birth - 18 years who is handicapped, (who has developmental delays) or who is "at risk" for developmental delays (example: an infant may not have delays during the early months but may be "at risk" of developing these delays because he is hard of hearing or blind, etc.) and
- 2) they live in Missoula, Ravalli, Mineral, Flathead, Lake, Lincoln or Sanders County.

#### Cleft Lip and Palate Clinic

CDC, in cooperation with the SDHES, has been involved with the Cleft Palate Program since 1976, and has one of the four teams in the State. CDC is responsible for local coordination and follow-up care.



Clinics are held six times a year. During the morning of a clinic the client is evaluated by one of eleven team members. These include an otolaryngologist, plastic surgeon, orthodontist, dentist, speech pathologist, audiologist, nutritionist, public health nurse, social worker, pediatrician, and psychologist. The afternoon is reserved for staffings during which time the team members discuss each client's care and formulate recommendations for care. This information is then shared with the family.

### Scoliosis Clinic

The Scoliosis clinic was started in the spring of 1978 in an effort to provide medical follow-up to children screened in the schools who were suspected of having scoliosis. Clinics are held every other month. Although the clinics are sponsored by CDC, in cooperation with the SDHES, they are held at the Missoula Rehabilitation Center because of the availability of Missoula Community Hospital's x-ray department. The attending orthopedic surgeon is assisted by CDC's physical therapist, public health nurse and social worker.

### Genetic Screening and Counseling

The Genetic clinic started in September, 1978, and has as its goal to convey understanding of birth defects to affected families and enable prospective families to make decisions about childbearing. During the clinic, a specially trained physician talks to families about their family history, the medical facts of a genetic condition, including the risk of the condition occurring in future offspring, and the choices they have regarding prevention and treatment. CDC contracts with the Genetic Unit of the University of Colorado Medical Center for this service.

The above three clinics are provided at no cost to families. All initial diagnostic tests will be paid for by Handicapped Children's Services, unless a family has insurance to cover the costs. Any additional costs incurred during a re-evaluation must be assumed by the family unless it qualifies for HCS assistance.

Referrals to the clinics can be made by writing or calling CDC.

## DEVELOPMENTAL ASSESSMENT SERVICES

### Introduction

Developmental Assessment Services, Inc. (DAS) is a private, non-profit corporation funded under an agreement with the State Department of Social and Rehabilitation Services and the U.S. Department of Health, Education and Welfare. The goal of Developmental Assessment Services is to facilitate the development of a network to provide screening, evaluation and assessment, and case coordination services for handicapped children in Eastern Montana. The governing body of DAS is a seven-member board of directors selected to provide region-wide representation.

## Problem Statement

As is generally recognized, and specifically addressed by House Joint Resolution 72, enacted by the 45th Montana Legislature, a number of inadequacies exist in the delivery of services to handicapped children in Montana. Although several agencies have the responsibility for screening, not all children receive screening at an early age.

Since most of the existing screening is limited to Medicaid-eligible children, a large segment of the population is left unscreened. Furthermore, a number of screenings which are done are not interdisciplinary in nature, leading to a limitation in the types of handicaps detected.

## Methodology

DAS proposes to address these problems specifically in Region I, and more generally, attempt to evaluate the applicability of different service models to other rural areas of Montana. A system will be developed that will screen, either directly or indirectly through the interagency networks, all children in Region I at periodic intervals. Furthermore, through the provision of a comprehensive evaluation and assessment component, DAS will develop or participate in the development of a comprehensive individualized treatment plan for each child receiving this service. A vigorous case coordination and follow-up system will be developed to facilitate the implementation of each child's recommended treatment plan. Consultation services by DAS staff will also be provided to service providers and families.

## Priorities

As DAS is a new program with limited resources, it has become necessary to adopt the following policies regarding priorities for services and service development. It is important to remember these are only starting points and it is hoped the program will be able to expand its services in the future.

AGE: Priority will be early intervention. Therefore, the primary target group is 0-2 years, followed by 3-5 years, then 6-18, then 19-21 years.

GEOGRAPHIC AREAS: Although DAS is intended to serve the 17 Eastern Montana counties in Region I at the outset, one of the priorities will be to serve the areas which have most limited access to other similar types of services. It is not the intent to supplant, but to supplement service which other agencies already provide.

SERVICES: The following service components will eventually be offered by DAS: screening, evaluation, assessment, and case coordination. While it is recognized that existing screening mechanisms are not as comprehensive or effective as they might be, it is also true that a large number of children have been identified, through various types of formal and informal screenings, who are already in need of the evaluation and assessment component.



Therefore, the program has chosen to prioritize this component to meet the already identified needs before focusing on screening. Within that evaluation and assessment component, the types of evaluations and/or assessments that are not already available through existing community services, such as medical clinics, have been further prioritized. Beyond the evaluation and assessment component, the development of a case coordination system within DAS will be prioritized before developing a screening component.

#### Core Clinical Team

DAS employs the following specialists to provide the above-mentioned services to children and families in Eastern Montana:

Case Coordinator  
Psychologist  
Speech/Language Pathologist  
Nurse Practitioner  
Occupational Therapist  
Physical Therapist  
Audiologist

#### Summary & Evaluation

As its mission, DAS will act as a catalyst in the development of an ideal entrance, evaluation, treatment, and exit system for handicapped children in Eastern Montana. The model to be employed to accomplish this task will be a transdisciplinary approach to providing services. Initially, DAS will deliver these services on an outreach basis. However, in order to accomplish the task of reviewing different models for service delivery, a number of strategies may be employed and empirically tested. The following variables will be considered in this review:

- 1) Consumer evaluation of effectiveness and model preference
- 2) Cost estimates and comparisons of different models
- 3) Degree of actual implementation of the recommended treatment-plan.

#### Service Definitions

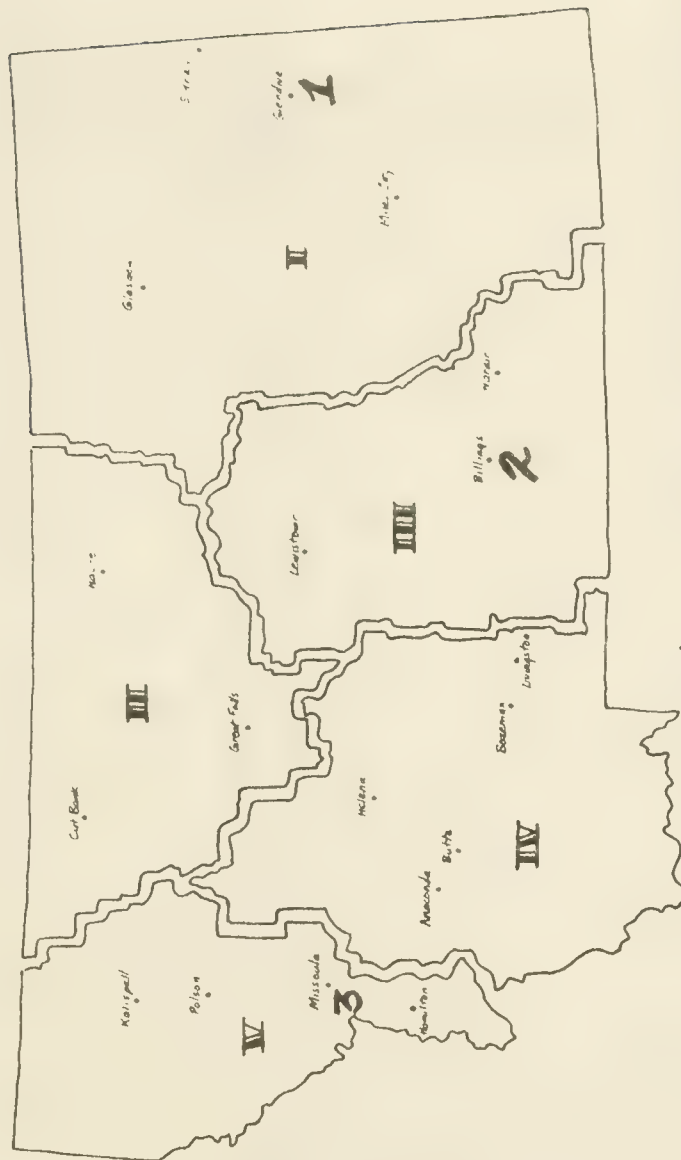
- 1) Screening: An assessment made to determine whether a child needs to be referred for treatment or further evaluation.
- 2) Evaluation and Assessment: An empirical process that determines if, and to what degree, an individual has developmental deficits, and what interventions and services are needed to reduce these deficiencies.
- 3) Individual Treatment Plan: A written plan of intervention and action that is developed by the interdisciplinary team on the basis of assessment results.
- 4) Case Coordination: Includes initial contact, intake procedures, assessment of service appropriateness, facilitation of the effective implementation of the individual treatment plan through follow-up contacts.

- 5) Consultation: Information and technical assistance to direct service professionals regarding the implementation of the individual treatment plan.
- 6) Transdisciplinary approach: A group of individuals consisting of the child's parents, teachers, support personnel, and other professionals who are in contact with the child (interdisciplinary team) collaborate in the development of an individual treatment plan. Direct implementation of the individual treatment plan becomes the responsibility of one or more members of the interdisciplinary team (primary therapist) with consultative back-up of the entire team.
- 7) Treatment: Actual implementation of the individual treatment plan. DAS staff will assist (when necessary) local "primary therapists" in carrying out the individual treatment plan.

The map on the following page shows the location of Montana's three Diagnosis and Evaluation Programs. Although catchment areas for the three programs are roughly Region I (DAS), Region III (CMHC) and Region V (CDC), all three programs serve clients who are referred from all areas of the state. The reason for this being that Montana lacks statewide coverage in its D & E services.

No 3B charts are provided with this subsection as any figures for persons served by Diagnosis and Evaluation Programs would duplicate figures provided by the agencies which fund D & E services throughout the state.

## MONTANA DIAGNOSIS &amp; EVALUATION PROGRAMS



- 1 - Developmental Assessment Services, Glendive
- 2 - Center for Handicapped Children, Billings
- 3 - Comprehensive Developmental Center, Missoula



TABLE 3.A

Service	CASE MANAGEMENT SERVICES					Agency: Various	
	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Program: D & E Programs	Follow-up Evaluation, D & E Svcs. Program
CDC	X	X	X	X	X		X
MCHC	X	X	X	X	X		X
DAS	X	X	X	X	X		X

TABLE 3.A

Service	CHILD DEVELOPMENT SERVICES					Agency: Various	
	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Program: D & E Programs	Prevention
CDC	X	X	X	X	X		
MCHC	X	X	X	X	X		
DAS	X	X	X	X	X		

Table 3.A

Service	MEDICAL SERVICES -					Agency: Various	
	Child Diagnostic and Evaluation	Surgery and Treatment	Speech Pathology-Audiology	Hospitalization	Physical Therapy Occupational Therapy	Program: D & E Programs	Clinical Program
CDC	X		X		X		X
MCHC	X		X				X
DAS	X		X		X		





Section 3

EASTMONT HUMAN SERVICES CENTER



## EASTMONT HUMAN SERVICES CENTER

Eastmont Human Services Center is located in Glendive, Montana, approximately twenty-eight miles from the North Dakota border. The facility is a state institution and is governed by Montana state law and administered by the Department of Institutions. The Center provides educational and habilitation training through two different residential options: a seven day care program and a five day care program.

Eastmont's five day care program was established by the 1967 Montana State Legislature as a new concept in the training of mentally retarded children in the state. The first students began attending classes in September, 1969, and moved into the five day residential cottages in October, 1969.

Eastmont's seven day care program was established by the 1979 Montana State Legislature to allow the transfer of mentally retarded residents of Boulder River School & Hospital to a smaller, less restrictive setting and to provide expanded services to the mentally retarded in Region I. The seven day care residential program is located in a forty bed facility which will be a licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Training is provided at the Center in seven major areas: Academics and Pre-Academics, Self Help Skills, Socialization, Pre-Vocational Training, Recreation Therapy, Home Living Training and Speech and Language Training. Community activities and interaction are actively encouraged as part of the ongoing program and every effort is made to keep parents and families actively involved in the residents' programming.

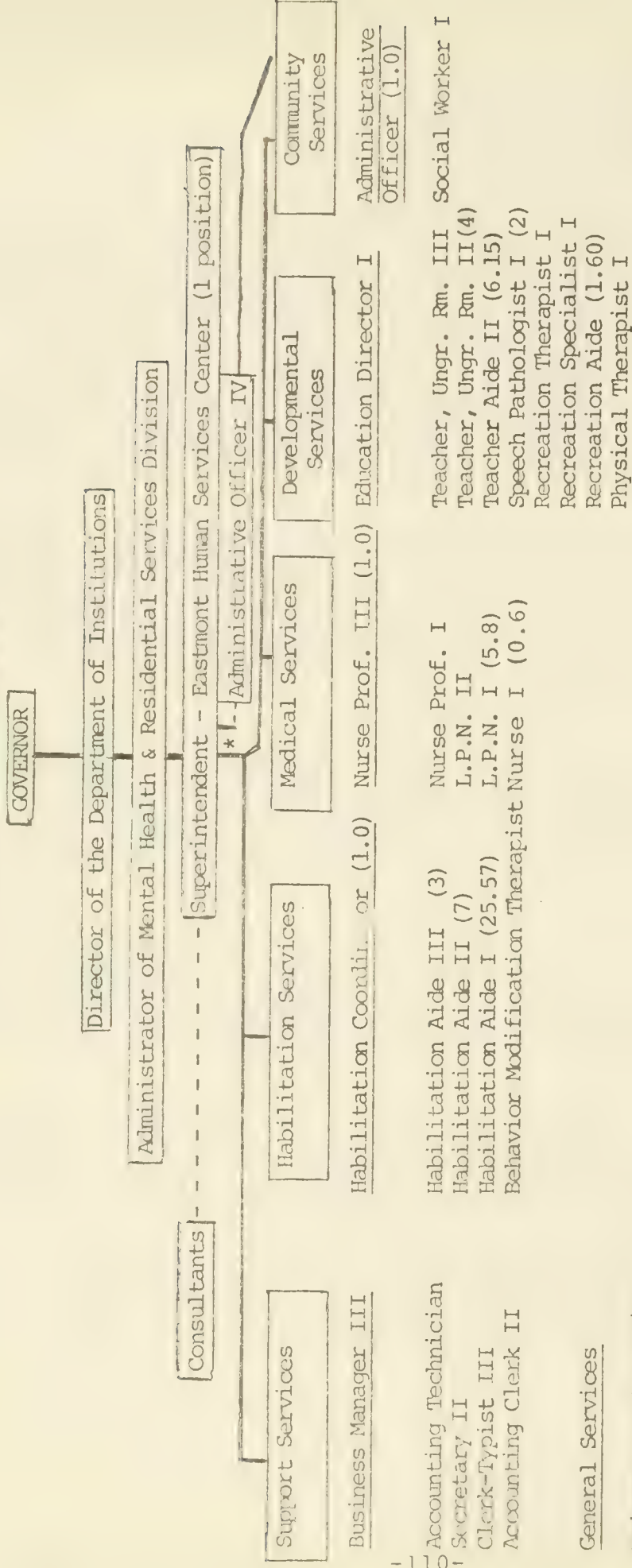
Eastmont's five day per week residents come from a seventeen county area in eastern Montana, and return to their homes every week-end and for special vacations throughout the year. The five day residents are between the ages of four and eighteen years and are from communities which do not provide appropriate training services to meet their individual needs.

Eastmont's seven day per week residents come from across the state of Montana, with the majority of the residents having been residents at BRS&H. These residents will participate in the Center's comprehensive training program, but will live at the facility year round.

Eastmont Human Services Center operates under the philosophy that our residents can be supportive members of society. We are helping them develop their abilities to meet the needs of today more adequately, however, they must constantly strive to meet and achieve the needs and demands of tomorrow.

# EASTMONT HUMAN SERVICES CENTER

## ORGANIZATIONAL STRUCTURE



\*This position acts as the Superintendent during his absence, plus performs additional administrative duties as directed by the Superintendent.

### General Services

Maintenance Supervisor II  
 Maintenance Worker I (2)  
 Transportation Officer I  
 Custodial Worker I (6.58)

### Food Services

Food Service Manager I  
 Cook III (2)  
 Food Service Worker III (1)  
 Food Service Worker II (3.2)



## Services Provided:

Self-Help Skill Training: Primary and secondary dressing skills, toileting, feeding, personal hygiene.

Academics: Pre-academics, functional academics, language, fine motor training.

Pre-Vocational Training: Work skills, fine motor training.

Home Living Training: Cooking skills, cleaning skills, laundry care skills.

Recreation: Gross motor training, arts and crafts, general recreation skills.

Socialization: Community orientation, peer interaction.

Behavior Management: Treatment for maladaptive behaviors and development of appropriate behaviors.

Speech and Language: Speech therapy, language skills, manual signing.

## Administration

Eastmont Human Services Center has 91.5 full-time employees (27.78 administrative; 63.72 direct care) and is administratively operated under five major departments: Administration Services, Habilitation Services, Medical Services, Developmental Services, and Community Services. The following Tables show the budget for the 1979 and 1980 State fiscal years.

### EASTMONT HUMAN SERVICES CENTER BUDGET ANALYSIS

#### TOTAL BUDGET

	<u>FY '79</u>	<u>FY '80</u>
State Share	\$462,905.	\$1,293,265.
Federal Share	<u>40,865.</u>	<u>47,746.</u>
Total	\$503,770.	\$1,341,011.

## BUDGET BY DEPARTMENT

	<u>FY '79</u>	<u>FY '80</u>
Administration Services	\$133,859	\$418,855
Care & Custody Services	189,515	446,442
Developmental Services	157,117	291,603
Community Services	23,279	36,924
Medical Services	-0-	147,187
	<u>\$503,770</u>	<u>\$1,341,011</u>

### Student Enrollment

The following Table shows student enrollment at Eastmont Human Services Center as of January, 1980, and the number utilizing each service as of January, 1980.

#### STUDENT ENROLLMENT

	<u>January, 1980</u>
Self-Help	39
Academics	30
Pre-Vocational	32
Home Living	8
Recreation	62
Socialization	27
Behavior Management	22
Speech & Language	47
Total Students	62
Total Residents	60

### Admissions and Discharges

Admissions are processed by the Community Service Department by consultation with staff. Admissions to Eastmont vary according to the type of residential program in which the resident will be participating. The five-day week program is operated on a voluntary admission basis, with parents and the student's home school district participating in the placement. These residents must be between the ages of four and 21 and must return to their natural home or a foster home on weekends. Admission to the seven-day per week program must follow the commitment procedure in a district court. There are no age limits for admission to this program.

Discharges occur when an appropriate placement becomes available in a resident's home community or when an opening occurs in a community based service system. All placements into the community are made with the cooperation of school officials, the staff of the community service which will be serving the resident upon discharge from Eastmont, and the Developmental Disabilities Division of SRS. Referral information includes a copy of the complete Individual Habilitation Plan and support information. The Eastmont staff will visit the proposed placement facility and meet with the staff of said facility at least once prior to actual placement.

At the beginning of each regular school year, each resident is evaluated using the Eastmont Adaptive Functioning Checklist. This checklist evaluates the resident's level of functioning in each of the training areas mentioned above, and allows the professionals from the various disciplines of training to make specific recommendations for programming for the coming year. These recommendations serve as the basis for the resident program, which lists the specific training areas the resident will be involved in, as well as listing specific time lines for goal achievement. The Individual Habilitation Plan is reviewed each month and appropriate additions and deletions are made to the resident's program. Parents review the Individual Habilitation Plan and sign off its appropriateness prior to its initiation. Additional evaluations are contracted (psychologicals, audiologicals, O.T., P.T.) and specific recommendations from these evaluations are incorporated into the student plan whenever possible.

For additional information about the IHP, see Section 8 of the Plan.

#### Current Goals and Objectives

1. To provide effective and efficient administration and operation of the Institution.
2. To employ an adequate number of appropriately trained staff and provide effective personnel management.
3. To provide three adequate, nutritious meals and necessary diets and supplements per day.
4. To provide a safe and sanitary environment for the residents.
5. To secure any available federal funds.
6. To provide and maintain educational and in-service training opportunities for staff.
7. To maintain existing supplementary programs.
8. To operate a complete transportation system for five day residents.
9. To improve or maintain the optimal physical health of all residents.
10. To insure compliance with state and federal regulations for medical services in a health care related facility.

11. To provide parent counseling regarding medical matters.
12. To provide individual assessment and programming annually.
13. To provide appropriate courses in the areas of (a) Academics; (b) Communications; (c) Self-Help; (d) Motor Development; (e) Recreation; (f) Socialization; and (g) Pre-Vocational.
14. To provide training for individual students to meet their specific needs.
15. To select and maintain appropriate training materials, equipment, and training space.
16. To provide optimum personal care and training for each resident.
17. To provide an environment in accordance with the doctrine of "Least Restrictive Environment".
18. To cooperate with all support services in the delivery of treatment.
19. To provide parent training.
20. To establish and maintain planning for admission, evaluation, and placement at Eastmont.
21. To provide planning and implementation for community placements from Eastmont.
22. To provide parent counseling and in-house social services.
23. To provide information, consultation, and referral services to families and agencies in developing community services.
24. To maintain a working relationship with all DD providers in the region.

# SERVICES PROVIDED

TABLE 3.A

Department of Institutions Eastmont Human Services Center							
Service	CASE MANAGEMENT SERVICES					Follow- Along	Evaluation of Svcs. Provided
	Assisting w/Access	Consultation w/ Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress		
1. Admissions & Discharges	X	X	X	X	X	X	
2. Speech & Language	X	X	X		X	X	

TABLE 3.A

Service	CHILD DEVELOPMENT SERVICES						Prevention
	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents		
1. Admissions & Dis- charges	X	X	X	X	X		
2. Self-help Skills	X				X		
3. Academics					X		
4. Prevocational Trng.					X		
5. Behavior Management					X		
6. Speech & Language				X			



SERVICES PROVIDED

TABLE 3.A

NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/ Civic Matters	Work/Day Activities
1. Self-Help Skill Training	X				X	
2. Pre-Vocational						X
3. Home Living Training	X				X	
4. Recreation				X		
5. Socialization	X				X	
6. Transportation		X				
7. Speech & Language	X				X	

## CASE MANAGEMENT - EASTMONT HUMAN SERVICES CENTER

Table 3. B

	Assisting with Access		CAPACITY FOR MORE			Follow Along		CAPACITY FOR MORE			Coordination of Services.		CAPACITY FOR MORE			Other Services		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
REGION																				
I																				
II																				
III																				
IV																				
V																				
East-mont	62	62				62	62				62	62				62	62			

## NUMBERS OF PERSONS SERVED

Table 3. B

## CHILD DEVELOPMENT - EAST AFRICAN HUMAN SERVICES CENTER

REGION	Early Intervention		CAPACITY FOR MORE		Counsel- ing of Parents		CAPACITY FOR MORE		Training of Parents		CAPACITY FOR MORE		Diagnosis & Evaluation		CAPACITY FOR MORE					
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I																				
II																				
III																				
IV																				
V																				
Eastmond	101	62				62	62				62	62				62	62			

1. Totals show contacts made in connection with various services, not total number of people served.
2. Constraints to services not available.

Table 3. B

## CHILD DEVELOPMENT - EASTMONT (CONT)

[illegible]

# NUMBERS OF PERSONS SERVED

Table 3. B NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES - EASTMONT

REGION	Assisting with Daily Living		CAPACITY FOR MORE			Work/Day Activities		CAPACITY FOR MORE			Other Services		CAPACITY FOR MORE			CAPACITY FOR MORE					
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	
I																					
II																					
III																					
IV																					
V																					
East- mont	121	121				32	32				146	146									





Section 3

MONTANA HEALTH SYSTEMS AGENCY



## MONTANA HEALTH SYSTEMS AGENCY

The Montana Health Systems Agency (MHSA) does not provide direct services, rather the agency plans for hospital, medical and other health services in Montana.

The MHSA's planning activities include the development of guidelines, criteria and policies for 18 separate categories of health services in Montana. Goals and objectives relating to nine of those health services are included in this section of the DD plan, as being the most specifically related to the DD service system.

The purpose of the MHSA planning activities is to develop quantified goals and objectives according to national guidelines and resource standards and to develop recommendations for substantive long-range actions.

The following descriptions of services, recommended goals and objectives and illustrations of locations of those services are excerpted from the MHSA 1980 State Plan which was developed by the MHSA staff and adopted by its board. The services described herein are as follows:

- Clinical cardiovascular laboratories and cardiac surgery facilities
- Computerized Axial Tomography (CAT) Scanner
- End-Stage Renal Disease (ESRD)
- Neonatal Intensive Care Units
- Acute Care Psychiatric Units
- Long Term Care Facilities
- Home Health Care
- Mental Health Services
- Comprehensive Rehabilitation Programs

## MONTANA HEALTH SYSTEMS AGENCY

### OVERALL PRINCIPLES

#### The Agency's Mission:

A principle purpose of the MHSA is to engage in health planning consistent with the mandates of Public Laws 93-641 and 96-79. As specified in the MHSA bylaws, its mission is to:

1. improve the health of the residents of the State of Montana;
2. increase the accessibility, continuity and quality of health services of the state;
3. restrain increases in the costs of providing health services; and
4. prevent unnecessary duplication of health services, manpower, and facilities within the state.

#### General Principles:

1. Health services should be cost effective.
2. Consumers must share the responsibility for their own health and the costs of health services.
3. Health education programs should be emphasized.
4. More emphasis should be given to the social components of health care, including, but not necessarily limited to, the special circumstances of the patient, his family, and the resources and the constraints of the community.
5. Health services should be coordinated at the local level to the maximum extent possible.
6. Primary care physicians should be recruited for shortage areas.
7. Alternatives to inpatient care should be encouraged.
8. Unnecessary duplication within the health field should be minimized.
9. The MHSA Plan should be developed with the intent of developing services for Montana where possible, practical and economically feasible.
10. The MHSA Plan should be developed so all providers are given reasonable and equitable compensation for the services they are expected to deliver.

CLINICAL CARDIOVASCULAR LABORATORIES  
AND CARDIAC SURGERY FACILITIES

This component deals with two highly specialized medical procedures to treat severe heart disease - cardiac catheterization and open heart surgery. Catheterization is a diagnostic procedure which often determines whether or not surgery should be performed. Four institutions in Montana - Billings Deaconess, St. Vincent (Billings), St. Patrick (Missoula), and Montana Deaconess Medical Center (Great Falls) - have developed clinical cardiovascular laboratories in which cardiac catheterizations are performed. The necessity of two clinical cardiovascular laboratories in Billings is questionable.

Billings Deaconess and St. Patrick Hospital are also performing open heart surgery. There are no institutions with the capability, specialists or equipment to perform cardiac surgery on infants. Consequently, these guidelines address only facilities providing adult services.

Based on a simplistic model, the MHSA recommends that no further facilities should be initiating cardiac catheterization services in Montana. It is recommended that Montana Deaconess Medical Center investigate by 1985 the feasibility of developing a surgical service to complement its cath lab.

MHSA GOAL:

Facilities offering cardiac diagnostic and surgical services should achieve and maintain a high level of expertise. In concert with this view, the following number of procedures should be performed annually by facilities providing these services:

- Cardiac Catheterizations - 300 caths/lab (Range - 100 to 500 caths)
- Open Heart Surgeries - 150 surgeries by each two physician team at the end of three years of operation (Range - 100 to 350)

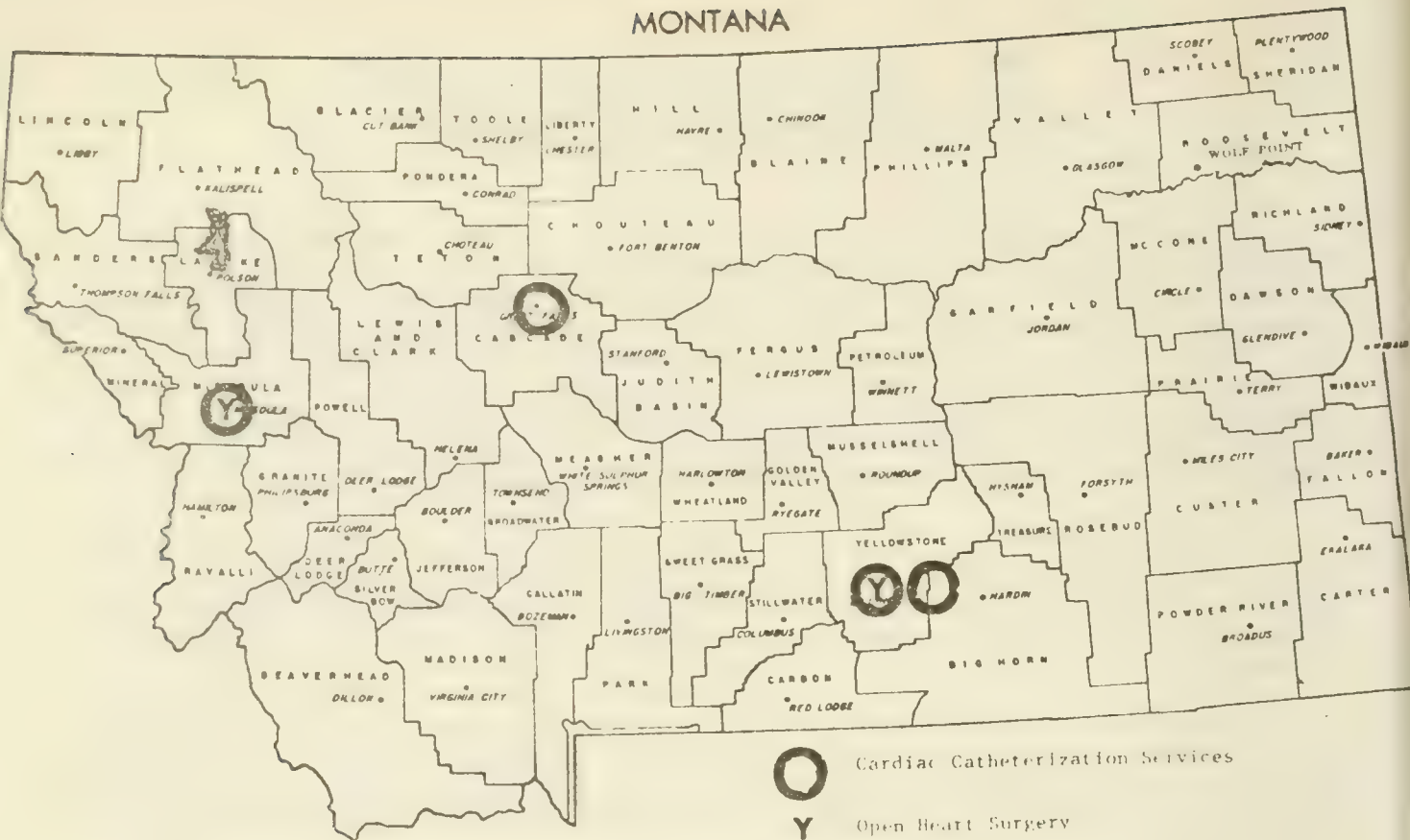
The number at the low end of the range provides a guideline for individual providers to perform and maintain proficiency. Operating below these levels for an extended period of time may result in decreased efficiency and lowered quality of service provided. The high number in the range is intended to represent average saturation levels for an individual laboratory or medical team.

MHSA OBJECTIVES:

1. The Montana Deaconess Medical Center in Great Falls should develop a cardiac surgery service by 1985.
2. Through 1985, no other facilities in Montana should develop these services unless the need for an additional service can be demonstrated.
3. By 1985, each cardiac surgery program in Montana should actively sponsor patient self-help groups, such as "Mended Hearts."



# MONTANA



Locations of Cardiac Catheterization &  
Open Heart Surgery Capabilities in  
Montana (1978)

## COMPUTERIZED AXIAL TOMOGRAPHY (CAT) SCANNERS

As a diagnostic tool for a wide range of head and body anomalies, the CAT scanner is a computerized X-Ray system which can produce cross-sectional pictures of the head or body, including pictures of organs obscured in conventional X-Ray photographs.

There are presently two whole body scanners in Montana, one in Great Falls at Columbus Hospital and another in Billings in the offices of Eastern Radiological Associates. A head scanner is also located at St. Patrick Hospital in Missoula.

Standards are suggested by MHSA, and based on this criteria it is recommended that no more than three CAT scanners should be located in Montana until utilization levels can no longer accommodate patient demand. Through 1985 any new CAT scanners must be justified based on cost effectiveness, scope and value of services, accessibility and availability of qualified personnel. Third party payors should be encouraged to include whole body CAT scans as a reimbursable item.

The following standards are suggested:

1. A whole body CAT scanner should operate at a minimum of 1,000 medically necessary scans per year for the first year of operation and 1,500 medically necessary scans per year for the second year of its operation and thereafter.
2. A head CAT scanner should operate at a minimum of 900 medically necessary scans per year for the first year of operation and 1,350 medically necessary scans per year for the second year of its operation and thereafter.
3. There should be no additional scanners approved unless the operators of the equipment will set in place data collection and utilization review systems and make that information available to the MHSA on an annual basis.
4. No additional CAT scanners (head and body or head only) should be approved for any geographic service area in Montana unless the utilization of each existing scanner in the geographic area will not decrease below the second year levels of (1) and (2) above as the result of the new service.

#### MHSA GOAL:

Based upon these criteria, no more than three CAT scanners should be located in Montana until utilization levels can no longer accommodate patient demand for CAT services presently being provided.

#### MHSA OBJECTIVES:

1. Through 1985, any new CAT scanners must be properly justified for placement in Montana based on the following criteria: cost effectiveness, scope and value of services, accessibility, and availability of qualified personnel.
2. Head scanners may be placed within the same service area as whole body scanners only if the new service does not decrease the total scans of the older service to a level below 1,500 scans a year or is otherwise properly justified.
3. Third-party payors should be encouraged to include whole body CAT scans as a reimbursable item.
4. CAT Scanners in private offices which are consistent with the Health Systems Plan should be deemed in compliance with certificate of need regulations for reimbursement purposes.

Montana

Counties and Seats:

- Adams: Libby
- Beauregard: Dillon
- Big Horn: Hardin
- Blaine: Phillips
- Bozeman: Bozeman
- Boulder: Boulder
- Butte: Butte
- Carbon: Carbon
- Cascade: Cascade
- Chouteau: Chouteau
- Cheyenne: Cheyenne
- Custer: Custer
- Dawson: Dawson
- Deer Lodge: Deer Lodge
- Golden Valley: Golden Valley
- Grant: Grant
- Glacier: Glacier
- Great Falls: Great Falls
- Helena: Helena
- Jefferson: Jefferson
- Judith: Judith
- Liberty: Chester
- Lincoln: Lincoln
- Minerva: Minerva
- Missoula: Missoula
- Moorehead: Moorehead
- Musselshell: Musselshell
- Park: Park
- Pendora: Pendora
- Petroleum: Petroleum
- Pink: Pink
- Plains: Plains
- Polk: Polk
- Powder River: Powder River
- Prairie: Prairie
- Richmond: Richmond
- Salt Lake: Salt Lake
- Sandwich: Sandwich
- Sawyer: Sawyer
- Sheridan: Sheridan
- Stillwater: Stillwater
- Teton: Teton
- Toole: Toole
- Townsend: Townsend
- Valley: Valley
- Wheatland: Wheatland
- Yellowstone: Yellowstone

Head Scanning

## Head and Body Scanning

### Location of CAT Scanning Capabilities in Montana (1978)

## END-STAGE RENAL DISEASE (ESRD)

End stage (chronic) renal disease is defined as that stage of advanced kidney failure or renal functional impairment which can no longer be managed by medication or diet modification and requires dialysis or transplantation for the maintenance of life.

At present there are four acute general hospitals in Montana which provide ESRD care. They are located in Helena, Great Falls, Billings and Missoula.

The incidence of end stage renal disease is currently about 60 new patients per million population per year. About 20 percent of these are transplant candidates; the remaining patients and those persons rejecting their transplanted kidneys must be dialyzed three times a week to stay alive. About half can be trained to perform home dialysis, while the other half must go to a local institution to have it done.

The MHSA recommends that home self-dialysis be emphasized in Montana. At the same time, it is recognized that facility capability must also be developed and maintained. Based on estimates, it is recommended that Kalispell consider developing this service and Butte, Bozeman, Southeastern and Northeastern Montana study whether or not it is feasible. Prevention programs such as hypertension screening efforts should also be emphasized in the next five years.

It is estimated that even with 40 percent of the Montana ESRD patients on home dialysis, the number of facility-based dialysis units will still have to be increased by 1985. Preference should be given to expanding existing facilities over establishing new units when this is done.

### MHSA GOALS:

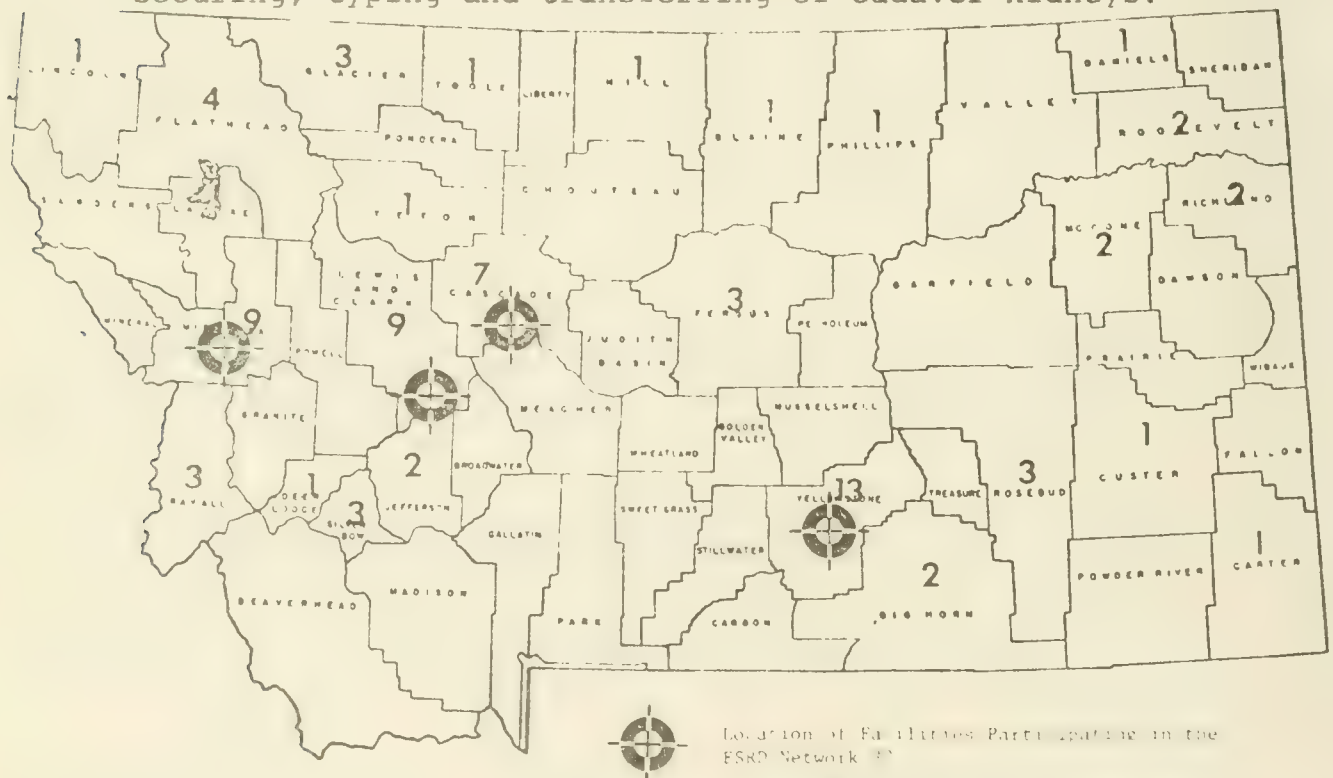
1. Home self-dialysis programs should be promoted in Montana. Although there is a strong indication the demand for facility hemodialysis will increase through 1985, at least 40 percent of the ESRD patients in each facility's catchment area should be on home dialysis.
2. Dialysis facilities which are geographically accessible to ESRD patients and yet economical should be developed.
3. A statewide program dealing with the prevention of end stage renal disease should be developed in Montana.

### MHSA OBJECTIVES:

1. By 1985 programs should be developed for home dialysis patients to provide the whole range of social services. Facilities providing ESRD dialysis services should provide or contract with agencies that do provide habilitative services.

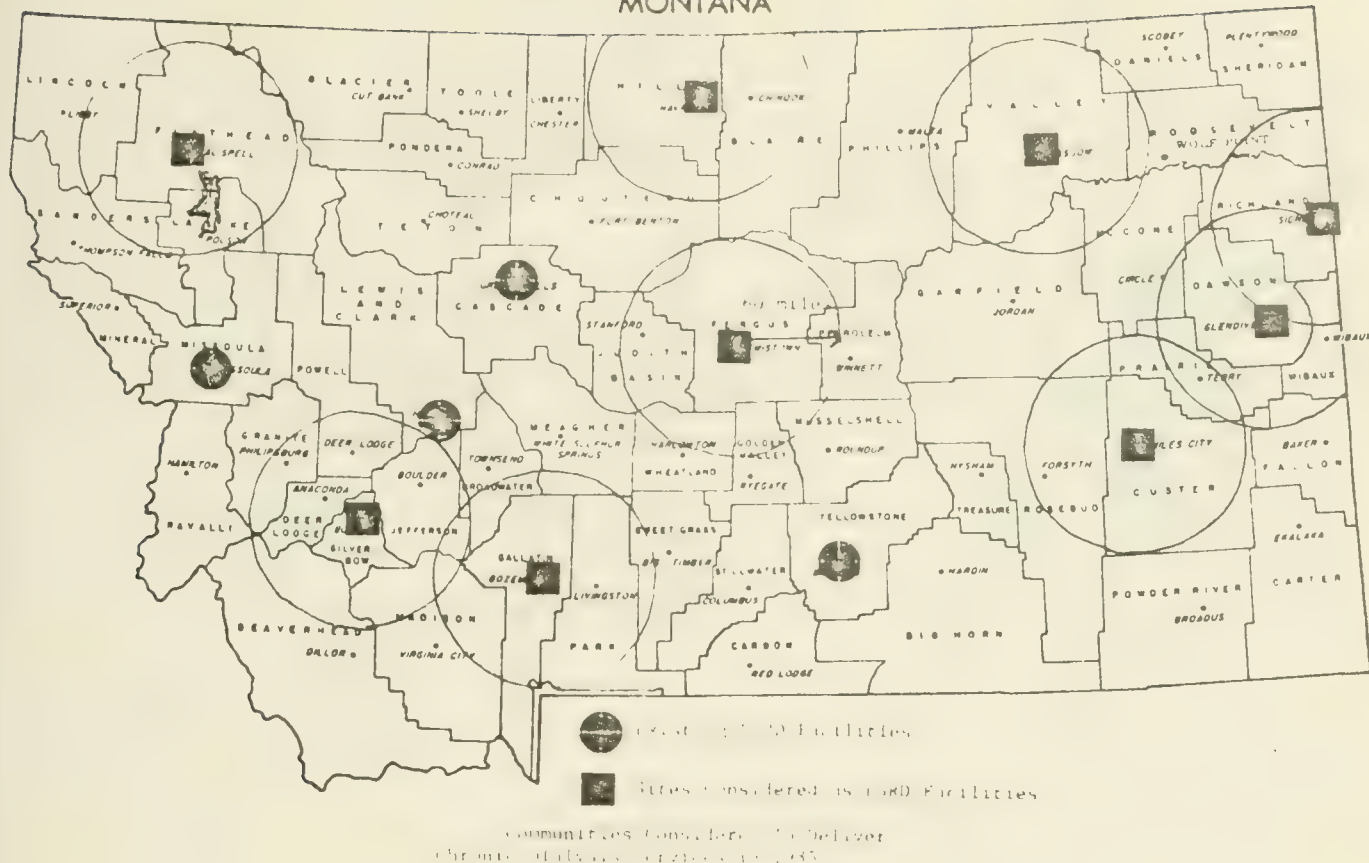


2. To urge physicians to implement the provisions of PL 95-292 so that payments to an individual assisting the patient in the dialysis procedures are a reimbursable expense. Home health agencies, for example, could provide backup assistance to home dialysis patients on an occasional basis.
3. By 1985, Kalispell should consider developing an ESRD in-center capability. The feasibility of delivering these services in Butte, Bozeman, Northeastern and Southeastern Montana should be studied.
4. By 1983, hypertensive screening programs with methods of referral and followup should be developed in Montana.
5. By 1983, educational programs directed to physicians and patients should be developed to emphasize the benefits of early diagnosis, treatment and management.
6. Research in the field of hypertension and kidney disease should be supported to aid in the development of preventive measures against end stage renal disease.
7. To educate the public about the importance of kidney transplantation as a treatment method and the desirability of donating kidneys for this purpose.
8. By 1985, explore the possibility of Montana participating in a cooperative venture with major transplant centers in the securing, typing and transferring of cadaver kidneys.





## MONTANA



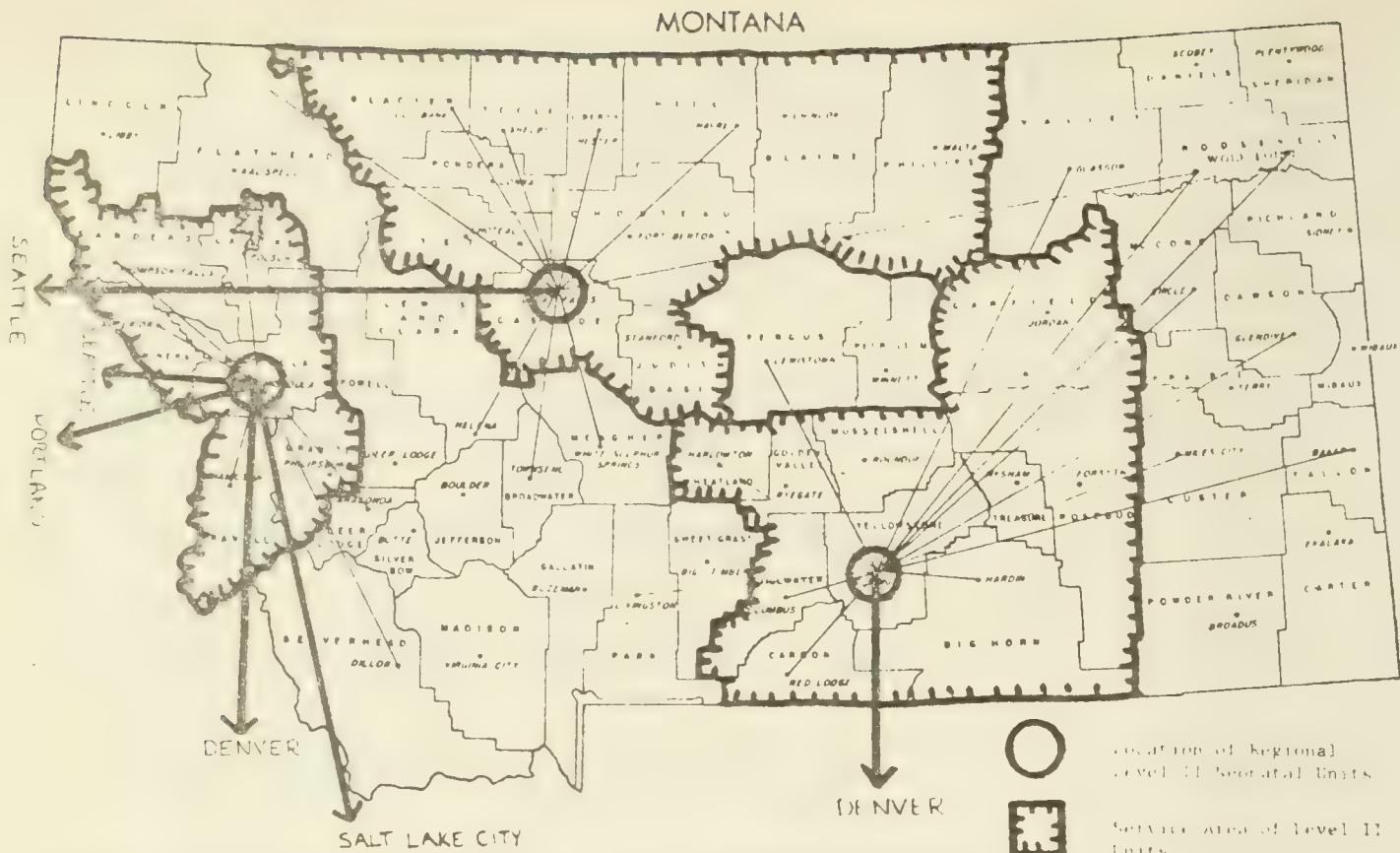
### NEONATAL INTENSIVE CARE UNITS

Hospital services for the premature newborn are categorized as Levels I, II and III. Level III units are restricted to medical school environments and so are not found in Montana. Level I units provide uncomplicated (low risk) maternity and newborn patient services. Level II units are located in larger urban and suburban hospitals providing an extended range of maternal and neonatal services requiring trained staff and modern equipment. The allocation and size of Level II units are the subject of this component.

The approach in this component is to strengthen the regional network already developed in Montana. Currently, there are six hospitals in Montana offering neonatal intensive care services. It is suggested that three of them - Billings, Great Falls and Missoula - be classified as Level II regional centers. The other three should continue to provide limited neonatal services to their surrounding communities.

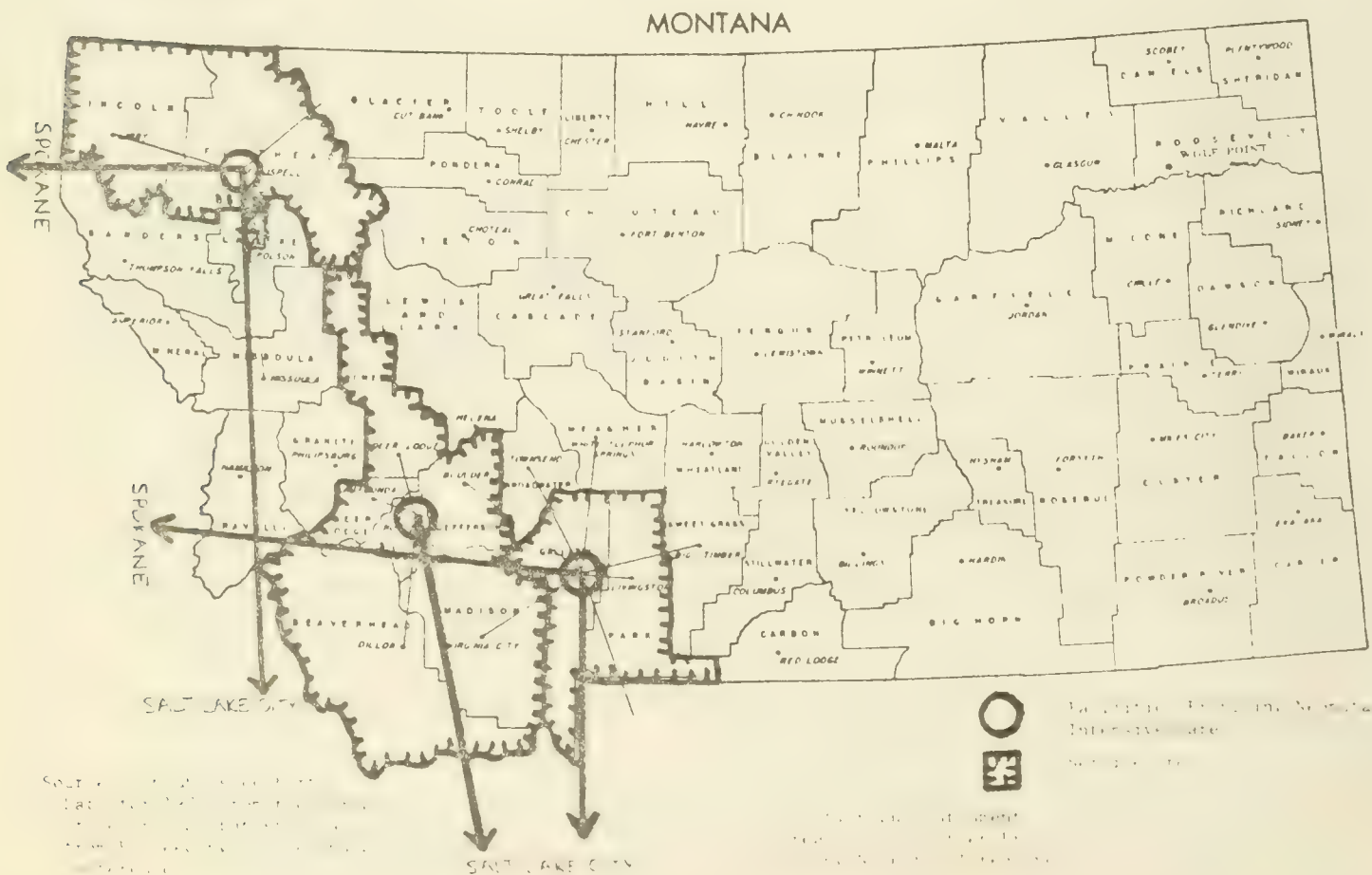
Using the model suggested by the MHSA, the state will need approximately 54 neonatal beds in 1985.

The MHSA would encourage physicians at Level I facilities to recognize and use the regionalized system of referral and transport and also seek funding for physician directors of Level II units.



Source: Unpublished Birth Data for 1978 from the Bureau of Economic & Statistics and from proceedings of Perinatal Conference.

Location and Catchment Areas of Facilities Providing Neonatal Intensive Care in Montana



#### MHSA GOAL:

The three existing Level II neonatal intensive care units in Montana should be maintained.

#### MHSA OBJECTIVES:

1. By 1985, develop funding sources for physician directors of Level II units.
2. By 1985, encourage physicians at Level I facilities to recognize and use the regionalized system of neonatal referral and transport.
3. By 1985, involve obstetricians in identifying high-risk mothers.

#### ACUTE CARE PSYCHIATRIC UNITS

In recent years the trend toward deinstitutionalization has increased the responsibility of local communities to provide services. This component is limited to establishing guidelines for the future development of regional psychiatric units in selected hospitals to serve those needing medically related care in the community.

These units are staffed by psychiatric nurses and other mental health specialists under the direction of a psychiatrist. Characteristically, patients admitted to these psychiatric units exhibiting behavior related to depression and psychosis stay for a relatively short period of time. Stays rarely exceed ten or eleven days.

The development of these units is heavily dependent on the recruitment of psychiatrists to the state. A possibility is using the National Health Service Corps to recruit the needed number of psychiatrists.

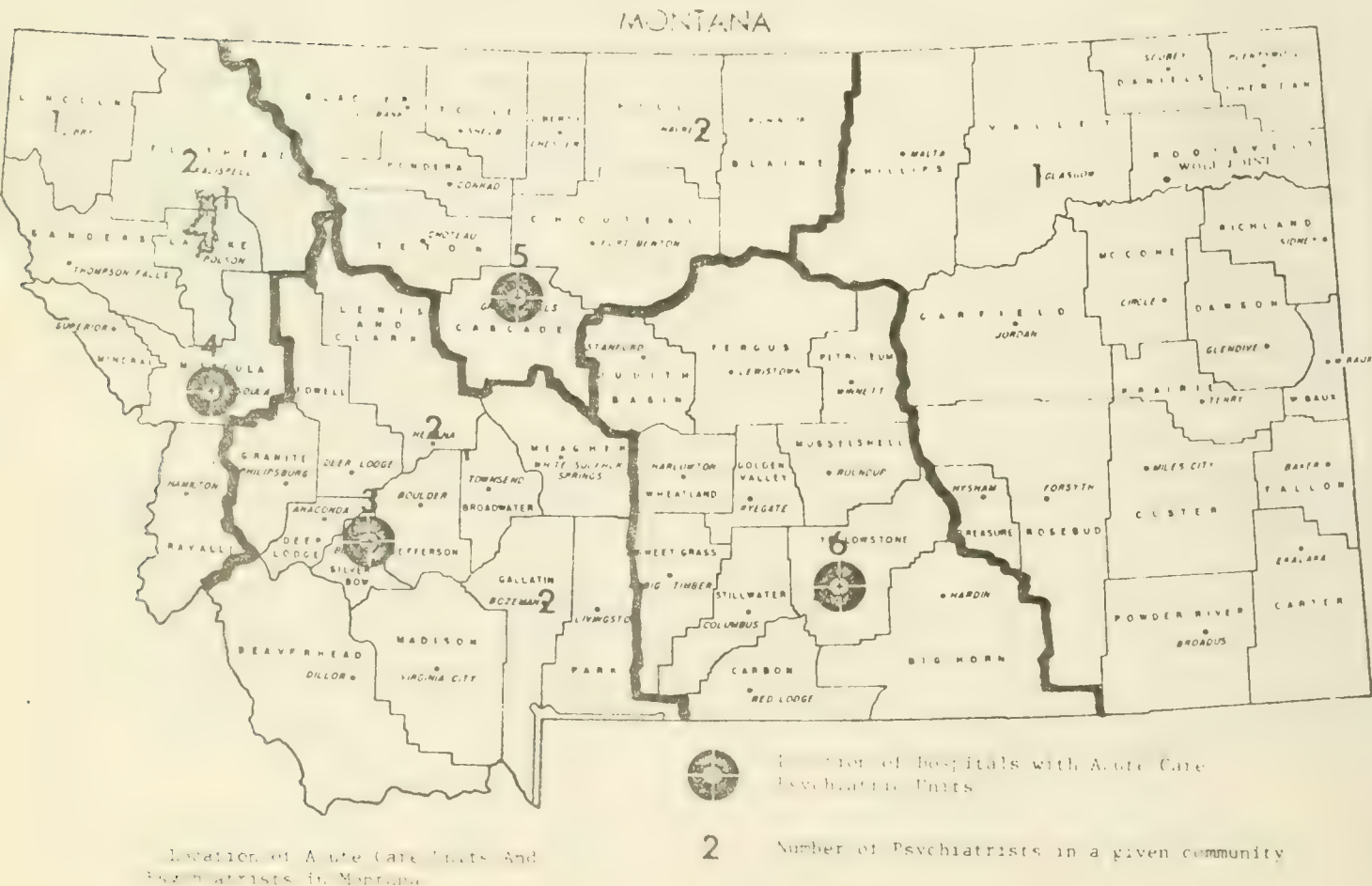
Kalispell, Helena, Havre and Bozeman may economically justify the development of acute care psychiatric units. It is recognized that a need exists in Eastern Montana for such care, but that a unit cannot be justified. The current methods of delivering acute care psychiatric services in Eastern Montana are to be supported.

## MHSA GOAL:

To foster the rational development of a number of regional, acute psychiatric units in Montana hospitals to provide short term psychiatric care. As a planning goal, bed need in this plan is based on a use rate of 69.8 patient days per 1,000 population.

## MHSA OBJECTIVES:

1. By 1985, establish short term psychiatric units in Kalispell, Helena and Bozeman if they can be shown to be financially feasible, and to serve a sufficient population to justify at least 10 beds without jeopardizing existing services in nearby cities.
2. By 1980, support legislation requiring all health insurance policies sold in Montana to include coverage of acute psychiatric services.
3. By 1980, emphasize the importance of linkages, coordination and cooperation between acute psychiatric units and local community mental health services. Cooperation between local inpatient and outpatient programs is vital to insure complete coverage.





## LONG TERM CARE FACILITIES

This component addresses those long term care beds medically necessary for health maintenance, providing inpatient care for the elderly, the convalescing, and chronic disease patients.

Although no data is available, there currently appears to be a shortage of personal care homes, group homes, adult foster care centers and geriatric day care centers. If these facilities are built and become operational, less demand for long term beds should be in evidence.

Using the classical Hill-Burton formula, with minor modifications, it appears that four service areas need 70 or more additional long term care beds by 1985. They are: Cascade (70 beds), Yellowstone (237 beds), Lewis and Clark County (85 beds), and Flathead County (113 beds).

With 5 counties presently having a surplus of over 20 long term care beds, and with the statewide ratio of 76.3 beds per 1,000 elderly population, the MHSA encourages the development of alternatives to long term care facilities, implementation of the swing bed concept and more appropriate placement practices for the long term care residents.

By 1980 a coordinated effort should be in evidence between the MHSA and other groups affiliated with the aged for the improved identification of problems facing the elderly.

### MHSA GOALS:

1. Long-term care beds should be readily and locally available to residents needing this type of care to avoid any excessive travel time to a facility and to avoid any psychological adjustments necessary by residents who otherwise would have to live far away from home. Future facilities should be designed to maintain at least a 90 percent annual average occupancy rate.
2. The appropriate placement of long-term care residents in nursing homes is to be encouraged.

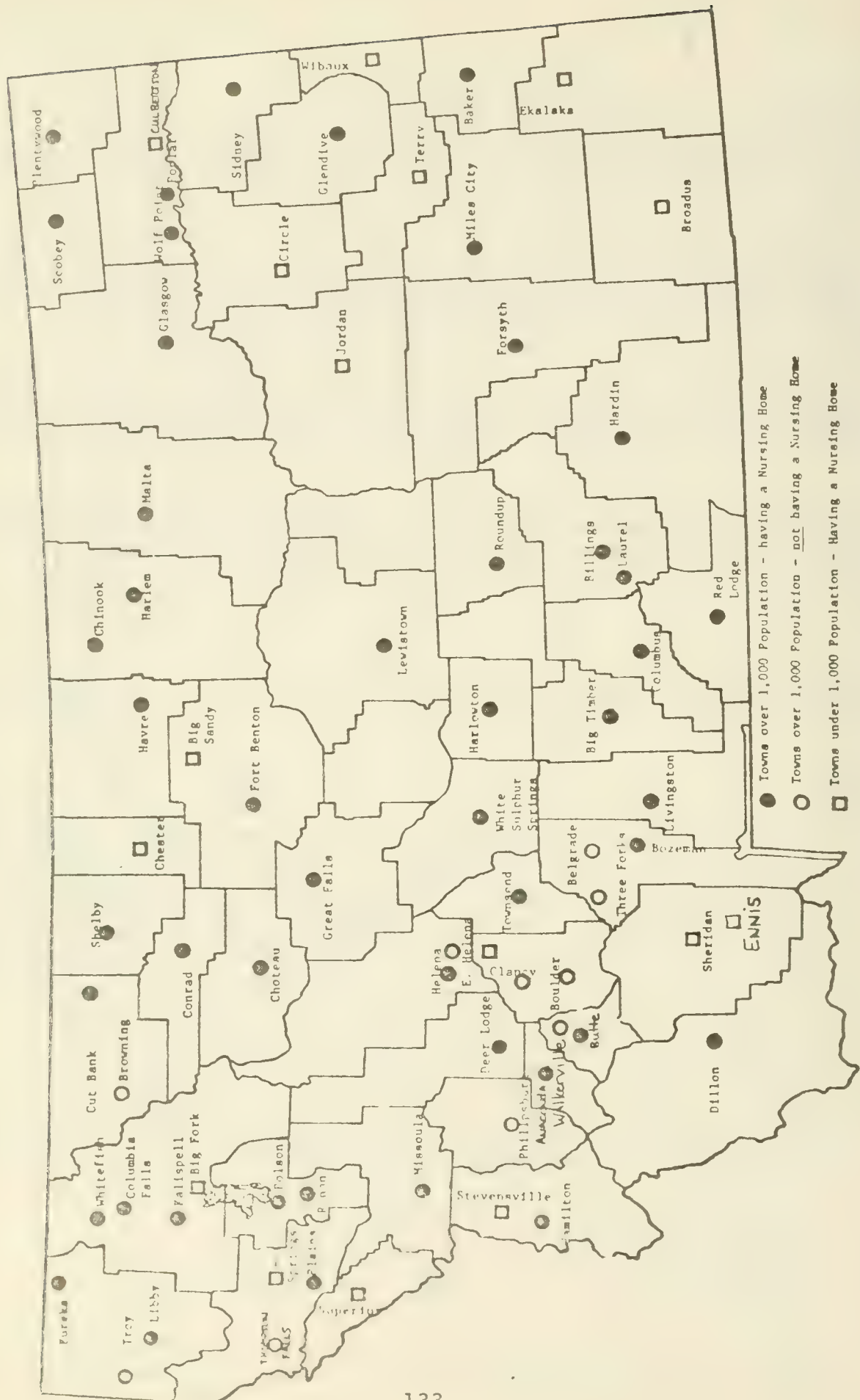
### MHSA OBJECTIVES:

1. By 1985, the following counties should consider constructing new or expanding existing long-term care facilities:

- Cascade	- Hill
- Yellowstone	- Gallatin
- Lewis and Clark	- Ravalli
- Flathead	- Glacier
- Custer	- Richland

However, no new facility construction should be approved until the applicant verifies that he fully investigated the feasibility of alternative modes of care.





● Towns over 1,000 Population - having a Nursing Home  
 ○ Towns over 1,000 Population - not having a Nursing Home  
 □ Towns under 1,000 Population - Having a Nursing Home  
 SOURCE: Based on 1977 Licensing List for Long-Term Care Facilities

Location of Long Term Care  
 Facilities in Montana

2. By 1982 the various sources of federal funds to assist in the financing of retirement homes, group homes and other less restrictive living arrangements should be identified. Programs providing seed money for the establishment of adult foster care programs, geriatric day care centers and home health care agencies should be identified and solicited. In addition, the MHSA should work toward a more stable reimbursement framework for these alternatives.
3. By 1980, efforts should be coordinated between the MHSA and other groups affiliated with the aged to identify the specific health problems of the elderly and the programs that could be implemented to alleviate these problems.

### HOME HEALTH CARE

Home health and supportive services are provided to patients in their own homes or in ambulatory settings for the purpose of preventing disease and promoting, maintaining or restoring health. It offers psychological benefits and possible cost savings over more restrictive settings and delivery systems.

By law, home health agencies in Montana are required to provide skilled nursing care and at least one other direct patient service. These may include: nutritional guidance, occupational therapy, physical therapy, speech and hearing therapy, respiratory therapy, medical social services and homemaker services. The age group primarily served is 65 years and older (the Medicare population), although developmentally and physically disabled confined to their homes are also served.

Funding is a major problem experienced by most home health agencies in Montana. It appears that Medicare participation is essential to stabilize any existing program.

The MHSA encourages the continued development of a multi-county service model in which local nurses and other personnel provide local services. Three of the largest agencies in Montana have developed using this concept. It appears that viable home health agencies can be established in the Lewistown, Glasgow, Glendive, and the Cut Bank - Shelby areas if a cooperative multi-county organizational structure were used.

#### MHSA GOAL:

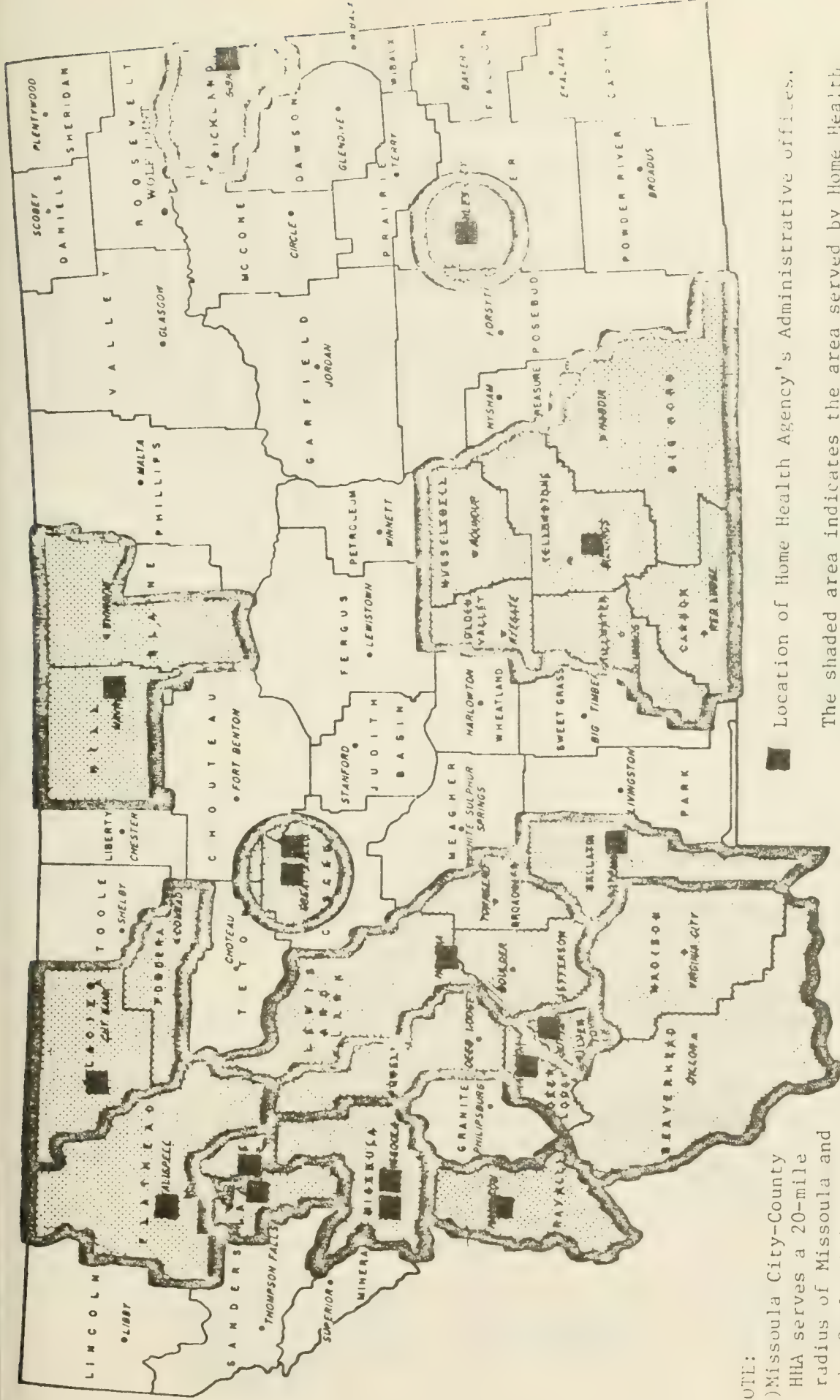
Home Health Care should be available and easily accessible to all Montanans while at the same time minimizing duplication of service areas. As a planning goal each agency should be able to maintain an active case load of at least 150 clients to remain financially viable.

## MHSA OBJECTIVES:

1. By 1982, encourage the establishment of home health agencies, if they can be shown to be financially feasible, in three different areas which are currently unserved.
  - Lewistown Area
  - Glasgow and Wolf Point Areas
  - Cut Bank, Shelby, Conrad and Choteau Areas
  - Glendive, Wibaux and Baker Areas
2. By 1985, encourage the expansion of four existing agencies into geographical areas currently unserved. In addition, encourage small agencies to expand the scope of services where financially feasible.
3. By 1983, monitor the activities of those agencies delivering services in the same geographical areas to ensure minimal duplication.

The primary means of implementing these strategies is through the Certificate of Need and appropriateness review process. However, before providers will be encouraged to undertake such a project, a number of activities need to be performed. These include:

4. Encouraging third party payors to expand coverage of home health services (within limits to avoid excessive services.)
5. Developing educational programs to make the general public more aware of the content, availability and need for home health services.
6. Developing programs to make physicians, nursing home personnel, and discharge planning personnel in hospitals more aware of the potential advantages of home health care.
7. Encouraging the continuance of federal grant programs to provide start-up monies and expansion funds for home health agencies.



NOTE:

1) Missoula City-County HHA serves a 20-mile radius of Missoula and the Seeley Lake area.

2) St. Joseph HHA (Polson) also serves the Hot Springs area of Sanders County.

3) The Blackfeet HHA is not yet operational in its entire catchment area.

■ Location of Home Health Agency's Administrative offices.

The shaded area indicates the area served by Home Health Agency.

Location and Catchment Areas  
Of Home Health Agencies in Montana (1979)



Subarea and Home Health Agency	Nursing	Homemaker	Physical Therapy	Occupational Therapy	Speech & Hearing Therapy	Medical Social Services	Nutritional Guidance	Respiratory Therapy	Pharmaceutical	Clinical Laboratory	Equipment & Supplies
<b>Northwestern</b>											
Ravalli County Public Health Nursing Service					not available						
Missoula City-County Health Dept. (HHA)	X		X	X	X						X
Missoula Rehabilitation Center	X		X	X	X	X	X				X
Flathead County Home Health Agency					not available						
St. Joseph Home Health Care Agency	X	X	X	X	X	X	X	X	X	X	X
Lake County Home Health Agency	X	X	X								X
Mineral County Home Health Agency					not available						
<b>North Central</b>											
Montana Deaconess Medical Center Home Health Agency	X		X	X	X	X	X	X	X	X	X
Columbus Hospital Home Health Agency					not available						
Northern Montana Hospital (HHA)	X		X					X			
Blackfeet Home Health Service	X		X		X	X				X	X
<b>Southwestern</b>											
Area V Home Health Agency	X	X	X								X
City-County Home Health Service (Butte)	X	X	X		X	X	X	X			X
West-Mont Home Health Care, Inc.	X	X	X	X	X	X	X	X			X
Gallatin County Health Department					not available						
<b>South Central</b>											
Yellowstone City-County Health Visiting Nurse Service	X	X	X	X	X						X
<b>Eastern</b>											
Nursing Care in the Home	X										
Holy Rosary Hospital Home Health Service	X		X		X	X	X	X	X		X

1) Supplies only

### Services Offered By Licensed Home Health Agencies in Montana (1978)

Source: Unpublished data from the Annual Survey of Home Health Agencies 1978. Montana State Department of Health & Environmental Services



## MENTAL HEALTH SERVICES

This component indicates MHSA recommendations about the designation of Critical Psychiatric Shortage Areas and the future use of NHSC psychiatric personnel in the state.

The plan addresses the roles of the Department of Institutions, Regional Community Mental Health Centers, and the state operated mental health facilities.

Deinstitutionalization is still the major policy being implemented within the state's mental health network. One problem to be faced in the near future is the lack of stable funding for the comprehensive mental health centers. Three of the five centers are now operating under federal distress grants.

Deinstitutionalization has been effective in reducing the number of patients treated at Warm Springs State Hospital. Between 1976 and 1978 the average daily census dropped 32 percent and the licensed bed capacity was decreased by 50 percent. During the same period, utilization at the Center for the Aged increased 36 percent.

The Mental Health State Plan calls for the continued orderly development of the mental health network established in Montana. The only major expansion effort identified in the plan is the development of an intensive care home for 10 to 12 emotionally disturbed children in Great Falls in fiscal year 1980.

The plan calls for an increased emphasis to be placed upon consultation, public education and prevention activities.

The MHSA has recommended that Eastern Montana, the Eastern Montana Mental Health Center, the Lewistown area, Warm Springs State Hospital, and the Northwest Mental Health Center (Missoula) be designated as Critical Psychiatric Manpower Shortage Areas.

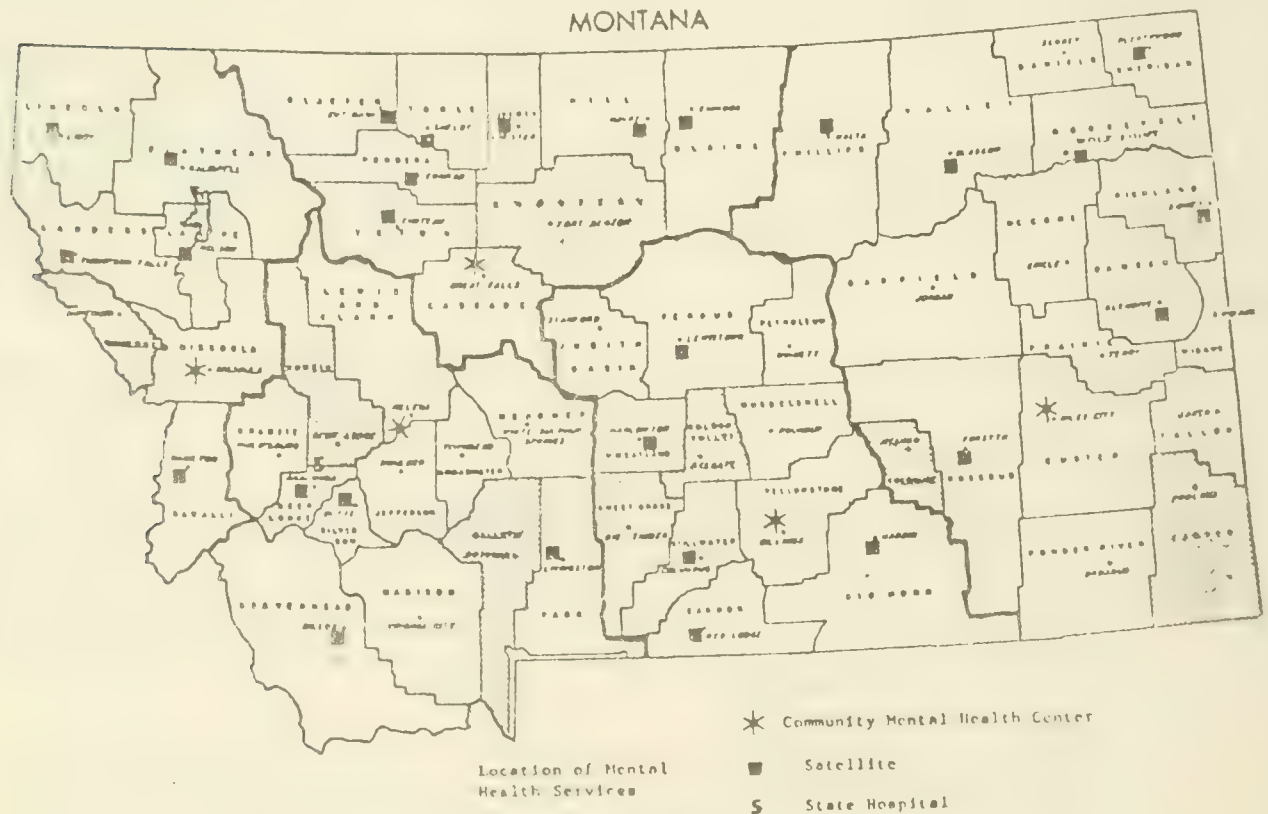
### MHSA GOAL:

Appropriate mental health services should be available to all Montanans.

### MHSA OBJECTIVES:

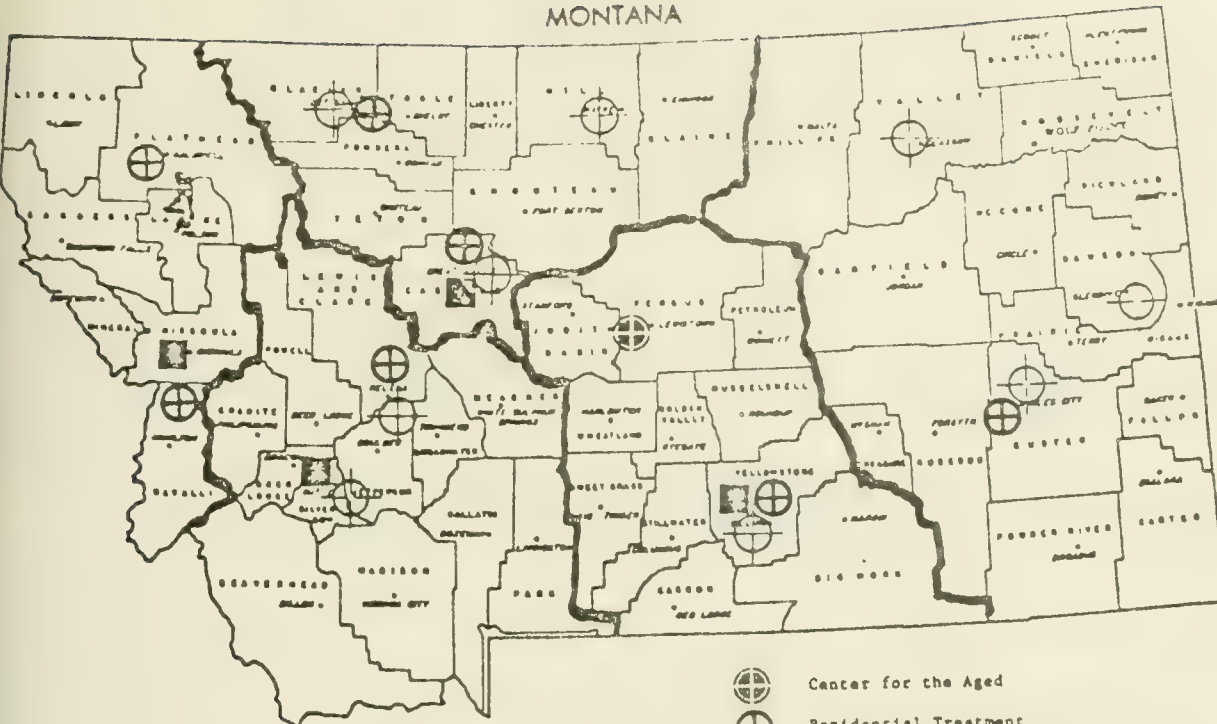
1. By 1985, the Community Mental Health Centers, private practice mental health providers, Warm Springs State Hospital and local and county program activities should be coordinated into a mental health network to provide care and treatment for the mentally ill and to encourage efforts toward the prevention of mental illness.
2. By 1980, the Department of Institutions' Mental Health and Residential Services Division shall develop a comprehensive, fair, and adequate long-range funding formula to ensure the existence of mental health delivery services on the community level.

3. By 1985, mental health manpower within each of the 12 administrative districts of Montana shall be increased to include at least one psychiatrist and at least one-half the national per capita average of all mental health team members (psychiatrist, licensed psychologist, psychiatric social worker, psychiatric nurse, other support clinical workers).
4. By 1980, there will be a comprehensive plan for the training and education of Montanans in mental health manpower shortage areas.
5. By 1982, the Manpower Project of the Department of Institutions should improve coordination with both public and private agencies resulting in policy agreements impacting productivity, regulation, utilization, deployment, retention and evaluation of mental health personnel.
6. During Fiscal Year 1981 the Mental Health and Residential Services Division should develop quarterly and year-end reports on goal and objective achievements.
7. By 1981, there will be a comprehensive prevention plan available to all Montanans through satellite mental health centers which will include such modalities as parent effectiveness training, behavioral modification, community skills and stress in the environment.



Source: Division of Mental Health, Department of Institutions

# MONTANA

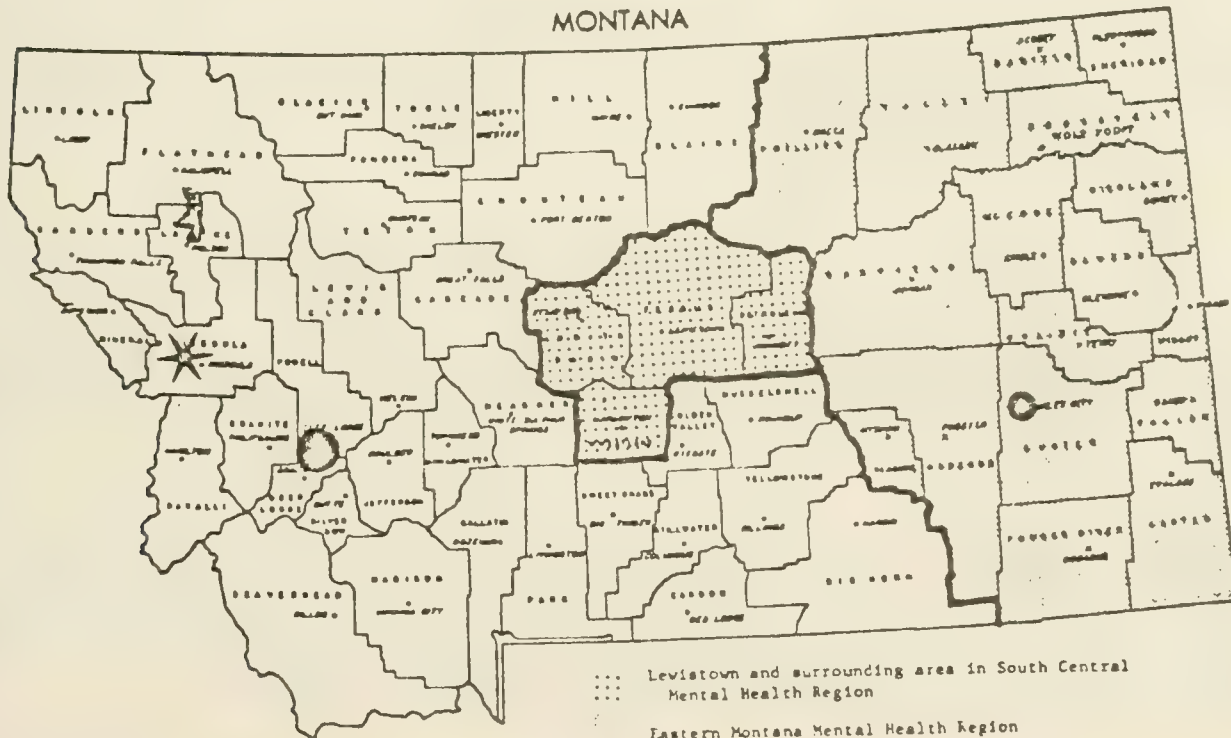


Location of Mental Health Facilities in Montana

Source: Division of Mental Health, Department of Institutions

- Center for the Aged
- Residential Treatment
- Inpatient Units
- Day Treatment

# MONTANA



No. 100 - Census Bureau Map  
STATS PUBLISHING COMPANY  
1960

Areas and  
Institutions in Montana Recommended  
To be Psychiatric Manpower Shortage  
Areas

- Lewistown and surrounding area in South Central Mental Health Region
- Eastern Montana Mental Health Region
- Warw Springs State Hospital
- Regional Office, Eastern Montana Mental Health Center
- Regional Office, Northwestern Montana Mental Health Center



## COMPREHENSIVE REHABILITATION PROGRAMS

This component stresses the development of a coordinated system for the provision of rehabilitation services. Patients served by these rehabilitation programs include victims of stroke, paraplegia and quadriplegia, multiple sclerosis, muscular dystrophy, arthritis, amputation and head injuries.

Only those rehabilitation programs having two or more of the following characteristics are addressed in the component:

1. The program is under the supervision of a physiatrist or a formally designated, full-time medical director.
2. The rehabilitation program is accredited by either the Commission on the Accreditation of Rehabilitation Facilities or the Joint Commission on the Accreditation of Hospitals.
3. The program has comprehensive, short-term rehabilitation beds.

It is recommended that the development of a rehabilitation program in Southwestern Montana be explored. There are currently comprehensive rehabilitation programs being developed in Missoula, Great Falls, and Billings.

The Montana Health Systems Agency suggests that programs planning to have comprehensive, short-term rehabilitation beds should consider the guidelines for bed need as prescribed in the component. The recommended review criteria state that existing beds should be occupied at least 80 percent of the time. Standards for all rehabilitation programs should comply with the Commission on the Accreditation of Rehabilitation Facilities or the JCAH.

### MHSA GOAL:

The development of a coordinated system for the provision of rehabilitation services in Montana should be promoted. Missoula, Great Falls, and Billings are developing comprehensive rehabilitation programs to serve the State of Montana. Rehabilitation programs should provide comprehensive rehabilitation services to assure continuity of care.

### MHSA OBJECTIVE:

The feasibility of developing a rehabilitation program in the Southwest service area should be explored. The cooperation of representatives from the existing rehabilitation programs (St. Vincent's Hospital, Missoula Rehabilitation Center, and Montana Deaconess Medical Center) and the Montana Health Systems Agency should be solicited for the study.

	Prevalence Per 100,000 (U.S.) <sup>1</sup>	Incidence Per 100,000 (U.S.) <sup>2</sup>	Estimated No of people in Montana with the Affliction	Estimated New Cases Annually In Montana
Stroke	754.9	105.8	5,745	805
Quadruplegia <sup>3</sup>	30.0	...	224	...
Paraplegia <sup>4</sup>	50.0	...	373	...
Multiple Sclerosis	44.3	...	337	...
Muscular Dystrophy	98.4 <sup>5</sup>	...	748	...
Arthritis	9,024.6	846.9	68,677	6,445
Amputations <sup>6</sup>	134.8	...	1,026	...
Head Injuries	...	...	1,927	...

Prevalence represents the number of individuals with the disease or chronic condition at any given time per 100,000 population (1970 Census)

Incidence represents the number of individuals in a given population getting the disease or chronic condition in a given time period. 1970 Census figures are used

Cerebrovascular disease statistics.

Vital and Health Statistics, National Health Survey, National Center for Health Statistics, DHEW

Obtained from **The Killers and Cripples, Facts on the Major Diseases in the U.S. Today**, National Health Education Committee p. 200.

Absence of major extremities

Reported by the Department of Health and Environmental Sciences, EMS Bureau, 1977.

### Estimated Incidence and Prevalence of Selected Chronic Conditions U.S. and Montana

Source: U.S. Department of H.E.W., Public Health Service, Health Resources Administration, Prevalence of Chronic Conditions of the Genitourinary, Nervous, Endocrine, Metabolic, and Blood and Blood-Forming Systems and of Other Selected Chronic Conditions, 1973, pp. 18-19.



Rehabilitation Program	Full Time Medical Director	CARF Accredited	JCAH Accredited	Acute Care Beds Designated	Long-Term Care Beds Designated	Home Health Services
St. Vincent Hospital (Billings)	X		X	8 designated beds		
Missoula Rehabilitation Center (Missoula)	X	X			20 beds designated Missoula Community Nursing Home	Missoula Rehabilitation Center
Montana Deaconess Medical Center (Great Falls)		X		12 designated beds	Montana Deaconess	Montana Deaconess

Commission on the Accreditation of Rehabilitation Facilities  
Joint Commission on the Accreditation of Hospitals

### Comprehensive Rehabilitation Programs in Montana

1-1431

Rehabilitation Services Provided	Rehabilitation Programs		
	St. Vincent Hospital	Missoula Rehabilitation Center	Montana Deaconess Medical Center
Vocation rehabilitation services/placement	X	X	X
Rehabilitation nursing services:	X	X	X
Physical/occupational therapy and prosthetic training	X	X	X
Speech therapy	X	X	X
Audiological services	X	X	X
Psychiatric counseling	X	X	X
Services for the amputee	X	X	
Post surgery services	X	X	
Social services	X	X	X

Available June, 1979  
Registered Nurse with postgraduate training in rehabilitation  
Physical and Occupational Therapy only

Rehabilitation Services Provided Or  
Contracted For At Facility

Subarea (Service Area)	Total Medical/ Surgical Admissions in 1977	Expected Adult Rehab Admissions	Rehab. Patient Days	Average Daily Census	Beds Needed	Rehab. Beds Available	Deficit (Surplus)
Northwest	25,638	128	5,760	15.8	20	20	0
North Central	26,195	131	5,895	16.2	20	12	8
Southwest	23,767	119	5,355	14.7	18	0	18
South Central/ Eastern	30,234	151	6,795	18.6	23	8	15
State Total	105,834	529	23,805	65.3	81	40	41

Missoula Community Nursing Home recently designated a 20 bed rehabilitation wing specifically designed for patients from the Missoula Rehabilitation Center. This facility opened April 30, 1979. It is assumed that these beds fulfill the need for rehabilitation beds in the Missoula area.

### Rehabilitation Bed Need Estimates and Beds Available, by Subarea

No Tables 3.A or 3.B are included in this section since the Montana Health Systems Agency does not directly serve clients.



Section 3

MATERNAL & CHILD HEALTH

and

HANDICAPPED CHILDREN'S SERVICES





## MATERNAL AND CHILD HEALTH BUREAU

### Health Services Division

This Division has the primary responsibility for the provision and regulation of public health services, disease prevention, health screening and diagnostic services.

### Maternal and Child Health Services Bureau

The Maternal and Child Health Services Bureau (MCH) of the Health Services Division, Department of Health and Environmental Sciences has the combined responsibility for the Maternal and Child Health program unit and the Handicapped Children's Services (HCS) unit. In addition, the Bureau is responsible for other child health programs: The Early Periodic, Screening, Diagnosis and Treatment Program (funded under Title XIX of the Social Security Act through contract with the State Department of SRS), Family Planning Program (in addition to Title V, also funded under Title X of the Public Health Services Act and Title XX of the Social Security Act, the latter through contract with the Montana State Department of SRS), and the Women, Infants, and Children Supplemental Food Program (funded under a U.S. Department of Agriculture grant).

### Administration

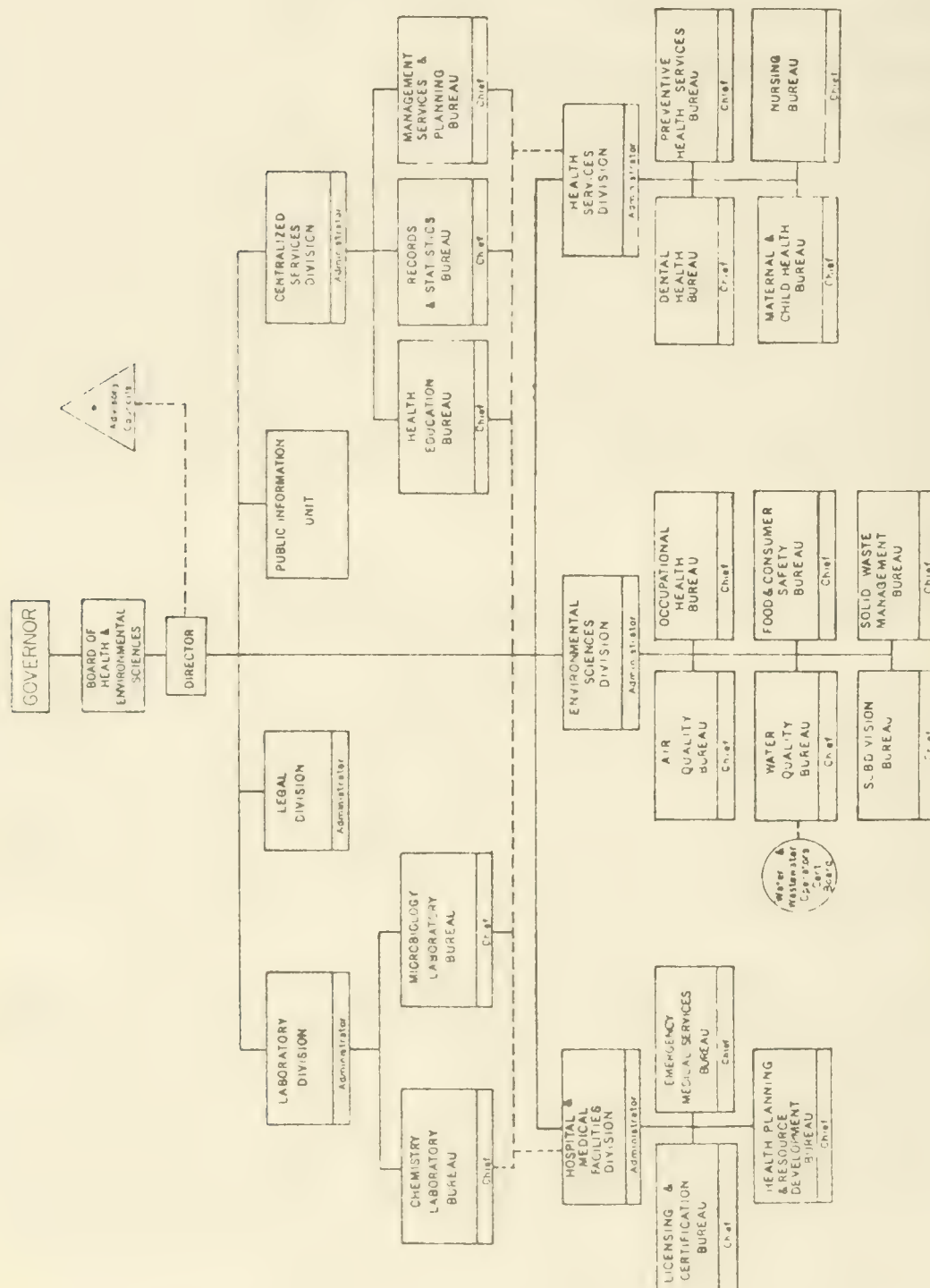
The Bureau is under the direction of a fulltime bureau chief who must have graduated from an accredited school of medicine.

The Bureau Chief has an assistant who aids in administering the financial, personnel and data requirements of the program. Program administrative responsibilities are further divided among staff who have planning, promoting, and coordinating responsibilities in the following major areas: Maternal and Child Health Nurse related services, Early Periodic Screening, Diagnosis and Treatment (EPSDT), Family Planning Services, Nutrition Services, Women, Infants and Children Supplemental Food Program, Handicapped Children's Services, Dental and Hearing Conservation Services.

The administration of these services is accomplished by a combination of direct administration by the MCH and by administration by local public agencies which are under contract to perform services specified by the MCH.

In those instances when local public agencies provide services, a contract specifying those services is established between the local public agency and the MCH. Performance and fiscal data specified by the MCH provides for audit of source documents to verify reported data.

# ORGANIZATIONAL CHART DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES



## Programs

MCH programs with greatest impact upon developmental disabilities services are MCH Related Services; EPSDT; Family Planning Services; Nutrition Services; Women, Infant and Children Supplemental Food Program (WIC), and Handicapped Children's Services. Of these program areas, the greatest direct impact upon the developmentally disabled population occurs within the Handicapped Children's Services program. However, the contribution of the EPSDT, Family Planning and WIC programs to the prevention of DD is a substantial one. Because of a delay in the development of the agency's data system, information for an accurate program analysis is not available at this time. An analysis of cases, by disability will be available once the agency's data collection mechanism is fully implemented.

The following are program descriptions:

1. Maternal and Child Health Nurse Related Services (includes perinatal education, well child services, Child and Youth Project, Maternity and Infant Project) - administered by the Bureau's Senior Nurse Consultant. Program objectives are:
  - (a) To reduce infant mortality rates in Montana from 15.5 to 12.9, which is the 10th percentile for the five year period of 1969-1973, as reported in the MCH Studies Project (Minnesota Systems Research, Inc. 1976).
  - (b) to reduce the perinatal mortality rate from 19.8 to 15.0.
  - (c) to establish adequate "well child" supervision for pre-school children in every county health department in Montana. These Well Child Clinics should ensure early casefinding and intervention to alleviate the effects of potentially handicapping conditions.
2. Early and Periodic Screening, Diagnosis and Treatment Program, administered by the EPSDT Program Manager. SRS has responsibility for all of the programs except direct screening services to non contracted counties.

Program objectives are:

- (a) Screen 30% of EPSDT recipients scheduled.
- (b) In collaboration with SRS, provide inservice training to local social services, EPSDT outreach workers and other involved parties to promote and better understand EPSDT Program.
- (c) 70% of the referrals will have followup.

3. Family Planning Services. The Montana Statewide Family Planning Program is administered by MCH.

MCH is responsible for the planning, development, and implementation of health services which impact the health status of mothers and children. The Family Planning Program plays an integral role in the Bureau and allocates federal Title X Public Health Service funds to 15 statewide programs to provide comprehensive family planning medical, educational, and social services. Federal Title XX monies also support the statewide family planning programs. A sliding fee scale, based on a client's ability to pay, is utilized by the programs for services. Priority is given to those from low income families.

These programs, preventive health based, provide counseling in all aspects of family life; educational services; blood tests for anemia, rubella and syphilis; immunizations for rubella; blood pressure recordings; physical examinations; cervical cancer screening; gonorrhea screening and treatment; pregnancy tests; urinalysis for sugar and protein; self-breast examination instructions; and dispensation of contraceptives.

Family planning services are directed toward the accomplishment of the following major health goals:

- Improve and maintain the emotional and physical health of men, women and children, particularly through the detection and prevention of cancer and venereal disease with women.
- Prevent birth defects and mental retardation.
- Reduce the incidence of abortion by preventing unplanned pregnancies.
- Assure that more children are "wellborn" by decreasing the incidence of prematurity and birth defects.
- Decrease maternal and infant mortality and morbidity.
- Assist couples who want to have children but can't.
- Prevent unplanned pregnancies, particularly in child abuse and poverty situations.
- Improve pregnancy outcome by correction of health problems between pregnancies and by proper spacing and timing of pregnancy.
- Assist couples in having the number of children they desire so that every child is intended and loved.



4. Nutrition Services are administered by the Bureau's Nutrition Consultant as part of the comprehensive Maternal and Child Health program. The primary objective of the Nutrition Program is to incorporate nutrition services into all health programs serving women in childbearing years and children in Montana.

Nutrition is being integrated into maternal health, family planning, infant and child health, including Handicapped Children's Services. The Special Supplemental Food Program for Women, Infants, and Children (WIC), a U.S.D.A. nutrition program, provides a strong linkage of health services for women and children. The U.S.D.A. Child Nutrition Program assists day care, Head Start and residential child care/institutions in providing nutritious meals to enrolled children.

Nutrition consultants provide technical assistance and training in understanding technical nutrition information and planning and evaluating the impact of nutrition services as a component of ongoing comprehensive health care.

GOAL: To improve the nutritional status of women during childbearing years, infants and children through the provision of these services in programs such as Family Planning, WIC, Perinatal Health (antepartum, postpartum and infant), Newborn Intensive Care, Well Child Clinics, EPSDT, Handicapped Children's Services, Child Nutrition Program, and the MCH Program of Projects and Special Demonstration Grants. The objectives of the program are as follows:

1. To develop, by September, 1982, criteria for minimally acceptable nutrition services in 100% of the MCH funded programs, such as Family Planning, Handicapped Children's Services, Maternal and Infant Care Projects, newborn intensive care, Child and Youth Projects, WIC and the Child Nutrition Program.
2. To establish and provide comprehensive and coordinated services for the maternal and pediatric population in at least 4 of the 5 multi-county regions in Montana by September, 1982. Each region will have a full-time Nutrition Consultant who shall be responsible for the coordination and provision of technical assistance, consultation, direct service, referrals, program planning and evaluation services to providers and consumers of these services. District IV is not included in this target as State MCH Nutrition Staff (MCH, WIC and Child Nutrition Program) shall provide consultation, technical assistance and direct services where no local nutrition services are available.



3. To continue the provision of nutrition technical assistance and consultation to health care professionals throughout the State in the areas of family planning, perinatal health and pediatric health care. In at least 25% of the annual meetings of Nurses, Perinatal Association, Montana Public Health Association, Cleft Palate, Dietetic Association, and other meetings, as appropriate, nutrition information shall be incorporated into the program.

4. To establish a data base which shall identify the prevalence of selected nutrition-related problems in the following population groups receiving services from MCH funded programs: 1) family planning; 2) prenatal; and 3) pediatric (with emphasis on birth-5 years).

- A. The WIC Supplemental Food Program is administered by the MCH Bureau and provides specified nutritious food supplements to pregnant and nursing women, and to infants and children up to 5 years of age who are determined by competent professionals (physicians, nutritionists, and nurses) to be at "nutritional risk" because of inadequate nutrition and inadequate income.

The purpose of WIC is to provide supplemental foods and nutrition education through local agencies to eligible persons. The program serves as an adjunct to good health care, during critical times of growth and development, in order to prevent the occurrence of health problems and improve the health status of these persons.

WIC began in Montana in 1974, with two pilot projects on the Fort Peck and Northern Cheyenne Reservations (caseload totaling 800 by the end of the year). In FY 80, the case load was 12,500 monthly, reaching participants in 36 counties. and on 7 Indian Reservations. The annual food and administrative funds allocated to Montana amounted to \$4 million. Eighty percent of the annual budget is used to purchase supplemental foods. The additional 20% is used for program operation, including: administration; the food delivery system; certification of clients; and nutrition education. Funds are made available to the MCH Bureau, State Department of HES, who in turn distribute these funds to participating local agencies, these funds are used to provide specified nutritious food supplements to WIC recipients and to pay the program operational costs. A computerized voucher system of food delivery is utilized by the State agency to provide supplemental foods to the target population.

The program's goal is to improve the quality of nutritional care for the target population of the Montana WIC Program with the ultimate goal of improving the health of the WIC participants. The objectives of the program include:

1. To emphasize the relationship of proper nutrition to the total concept of good health with special emphasis on the nutritional needs of pregnant and lactating women, and infants and children under five years of age.
2. To assist the individual at nutritional risk in obtaining a positive change in food habits resulting in improved nutritional status through maximum use of supplemental foods and other nutritious foods.
3. To maximize the use of supplemental foods within the context of ethnic, cultural and geographical preferences.
4. To provide access to preventive health programs and referral to private and public health providers.

B. Child Nutrition Program

The State agency began administrative responsibilities for the USDA Child Nutrition Program in October, 1977. The program provides funds to assist in the purchase of adequate and nutritious food for children under 19 years of age enrolled in licensed public or non-profit child care centers and outside-of-school-home care programs, in Head Start, in family or group day care homes, or in residential child care institutions. Specific meal patterns must be followed for all breakfasts, lunches, suppers and snacks served. Monthly reimbursements are provided to the facility based on the number and type of meals served and the income of the child's family. Six thousand children in 25 counties are presently being served.

For State fiscal year 1980, the budget for State administrative expenses for operation of the program was \$89,000. Projected reimbursements to local facilities for meals served is \$1.1 million. \$24,548 was available to the State agency for institutions for the purchase of food service equipment necessary to maintain or expand their child nutrition programs.

The policy of the State agency is to expand the program to the most needy children, within State agency staff and funding constraints. Family day care homes are targeted for special assistance.

Nutrition services provided to participating institutions include: on-site biennial evaluation of the nutrition and food service program, staff training, provision of current information on nutrition and health of children, consultation in nutrition program planning, guidance in managing special feeding problems, referral to appropriate consultative and materials resources, and provision of a Management Manual to follow in planning and operating the Child Nutrition Program.

5. Handicapped Children's Services (HCS) is administered by the HCS Program Manager. HCS, previously called Child Health Services or Crippled Children's Services, is undergoing a significant change. Program emphasis is no longer just a bill-paying service for specialty care.

The program goal is to provide a multidisciplinary approach for diagnostic evaluations and the management of long-term rehabilitative care for any child birth-21 with a chronic handicapping condition.

#### Authorization of Services:

All services provided by HCS must be pre-authorized by State HCS nurse consultants or the medical director. Emergency authorization may be given verbally by an HCS nurse or physician if the referral is received within 72 hours of the treatment. Record of such verbal authorizations must be included in the patient's file. The appropriate authorization forms are then sent to the vendor. Included in this policy are: diagnostic evaluation, x-rays, surgery, hospitalization, anesthesia, lab work, physical therapy, occupational therapy, speech therapy, orthopedic appliances, hearing aids, orthodontics, dentistry.

Acceptance of an authorization by the vendor carries with it an agreement that no charge will be made to or payment accepted from a patient or his family. Exception may be determined and authorized by HCS staff and requires agreement by the family.

No payment shall be made by HCS for unauthorized services for any care rendered before the date of referral.

Eligibility for program services begins from the date the referral is received by HCS.

Each treatment authorized by HCS is recorded in the individual's file. Amount of the authorization is logged and when payment is processed, the actual cost is also logged. The Montana Medical Association's relative schedule for costs is utilized in determining payment for physician fees.

Responsible hospitalization charges are determined by utilizing the Commission on Professional and Hospital Activities guidelines for needed length of hospital stay associated with specific treatment.



## Eligibility Requirements:

Long-term rehabilitative care of children having congenital handicapping conditions is often a heavy financial burden for a family to carry alone; thus the family's financial status is an important factor in determining eligibility for HCS financial assistance.

A second important factor for determining eligibility for HCS is the amount of medical expenses the family has incurred or paid directly (not paid by insurance) during the current year. These expenses are considered to be the family's financial participation in meeting medical costs.

A sliding fee scale revised in April, 1979, allows eligibility to be completed in a simple manner. Annual gross income of the family is used. The number of family members determines the required contribution amount before the family becomes eligible for HCS financial assistance.

Services provided by this program are;

### (a) Early Identification

Early identification of handicapping conditions is emphasized and efforts to increase such referrals are being stressed by WIC, EPSDT, Newborn Intensive Care Units, Well Baby and Well Child Services. The Bureau of Vital Statistics provides the MCH Bureau with copies of birth certificates identifying newborns with congenital malformations. The MCH Bureau also receives copies of certificates for fetal deaths; birth and death certificates for the neonatal and infant deaths; and copies of birth and death certificates for any case identified as a sudden infant death.

### (b) Diagnostic Services

Diagnostic evaluations of conditions are available to all children on a preauthorized basis. These may be received through a clinic setting or through a single specialty provider.

Any child legally residing in Montana, regardless of sex, race, or economic status is eligible to receive assistance with the cost of diagnostic care without charge by completing an HCS application. The evaluation must be pre-authorized by the HCS staff and the evaluation provided by a HCS Program approved specialist. A written report from the provider is required before payment will be processed for the evaluation.

In case of emergencies, the physician, nurse, or other referral source has 72 hours to phone in a request for services.

Reasonable effort will be made by HCS to collect the cost of care and service from third party payment sources. Authorization & payment for care by HCS is subject to insurance benefits. If the vendor does not submit an insurance claim the family is instructed to do so.

#### (c) Treatment Services

Because of the complexity of medical and related problems in the patients referred, HCS provides specialty care. Only medical personnel who are board certified or eligible for certification within their specialties can be approved to provide services to children eligible for HCS services. Rare and extenuating circumstances may exist in which the medical review team will authorize care to be provided by a medical person other than one certified or eligible for certification.

#### (d) Newborn Intensive Care

Included in the scope of Handicapped Children's Services is transportation of infants needing specialized newborn intensive care. Applications for services, case management services, and bill paying process are handled by the HCS personnel. The quality control and consultative services are provided by the MCH Nurse Consultant.

#### (e) Hearing

The HCS program also assists in the management of the hearing services for children offered by the Hearing Conservation Program by accepting applications, reviewing treatment plans, authorizing services and processing bill payment. The MCH audiologist and HCS staff coordinate services with the local providers.

#### (f) SSI - Disabled Children Program

The Maternal and Child Health Bureau HCS program also has the case management responsibility for handicapped children ages birth-16 receiving SSI payments. The program is responsible for assuring that children receiving these payments are receiving authorized services. The Bureau currently has case records for 275 children.

Handicapped Children's Services provided the following services to children during July 1, 1978 - June 30, 1979. The total number of children receiving HCS services was 1,517.



<u>Category of Care</u>	<u>Number of Children</u>	<u>\$ Amount Expended</u>
Cystic Fibrosis	11	\$ 5,150.15
Heart	48	97,354.71
Neurology	28	16,665.32
Bone	42	16,965.19
Congenital Deformities	71	66,391.50
Hearing	24	15,421.65
Maxiofacial	5	7,557.22
Other	50	25,573.95
Cleft Lip & Palate	108	65,302.32
Air Ambulance	<u>55</u>	<u>67,549.72</u>
TOTALS	442	\$383,661.73

35 children were in more than  
one category of care -35

TOTAL UNDUPLICATED COUNT: 407

<u>Evaluations/Speciality Clinics</u>	<u># Of Children</u>
Comprehensive Developmental Center	339
Heart Diagnostic Center	304
Center for Handicapped Children	374
Cleft Palate Clinics - Helena & Great Falls	<u>93</u>
	1,110

<u>CDC</u>	<u># of Children</u>	<u>Heart Center</u>	<u>CHC # of Children</u>
E & D	202	# of Children - 304	Med. Clinic 168
Sp. Clinics	137		Speech Clinic 75
Cleft	45		Dev. Assess. 31
Scoliosis	66		Myelodyspl. 18
Genetic	26		Cleft 48
	<u>339</u>		Genetic <u>34</u>
			374

**MONTANA**

**Counties and Major Cities:**

- Lincoln:** LIBBY
- Glacier:** CUTBANK
- Toole:** SHELBY
- Pondera:** CONRAD
- Flathead:** KALISPELL
- Sanders:** SANDERS FALLS
- Lake:** POLSON
- Superior:** SUPERIOR
- Mineral:** MINERAL
- Missoula:** MISSOULA
- Powell:** POWELL
- Granite:** PHILLIPSBURG
- Hanksville:** HANKSTVILLE
- Ravalli:** RAVALLI
- Deer Lodge:** DEER LODGE
- Chouteau:** CHOTEAU
- Teton:** TETON
- Liberty:** LIBERTY
- Chester:** CHESTER
- Mill:** MILL
- Chinook:** CHINOOK
- Blaine:** BLAINE
- Phillips:** PHILLIPS
- Valley:** VALLEY
- Glacier:** GLACIER
- Roosevelt:** ROOSEVELT
- Wolf Point:** WOLF POINT
- Richland:** RICHLAND
- Sidney:** SIDNEY
- McCone:** MCCONE
- Circle:** CIRCLE
- Dawson:** DAWSON
- Glendive:** GLENDIVE
- Prairie:** PRAIRIE
- Terry:** TERRY
- Wibaux:** WIBAUX
- Miles City:** MILES CITY
- Custer:** CUSTER
- Baker:** BAKER
- Fallon:** FALLON
- Ekalaka:** EKAŁAKA
- Carter:** CARTER
- Powder River:** POWDER RIVER
- Broadus:** BROADUS
- Garfield:** GARFIELD
- Jordan:** JORDAN
- Petroleum:** PETROLEUM
- Winnett:** WINNETT
- Fergus:** FERGUS
- Lewistown:** LEWISTOWN
- Musselshell:** MUSSELSHELL
- Roundup:** ROUNDUP
- Golden Valley:** GOLDEN VALLEY
- Regate:** REGATE
- Yellowstone:** YELLOWSTONE
- Billings:** BILLINGS
- Stillwater:** STILLWATER
- Columbus:** COLUMBUS
- Carbon:** CARBON
- Red Lodge:** RED LODGE
- Big Horn:** BIG HORN
- Hardin:** HARDIN
- Treasure:** TREASURE
- Rosebud:** ROSEBUD
- Hysham:** HYSHAM
- Forsyth:** FORSYTH
- Muskegon:** MUSKEGON
- Wheatland:** WHEATLAND
- Harlowton:** HARLOWTON
- Meagher:** MEAGHER
- White Sulphur Springs:** WHITE SULPHUR SPRINGS
- Townsend:** TOWNSEND
- Broadwater:** BROADWATER
- Gallatin:** GALLATIN
- Bozeman:** BOZEMAN
- Livingston:** LIVINGSTON
- Park:** PARK
- Madison:** MADISON
- Virginia City:** VIRGINIA CITY
- Beaverhead:** BEAVERHEAD
- Dillon:** DILLON

**EPSDT**

EPST

**MONTANA**

Counties and County Seats:

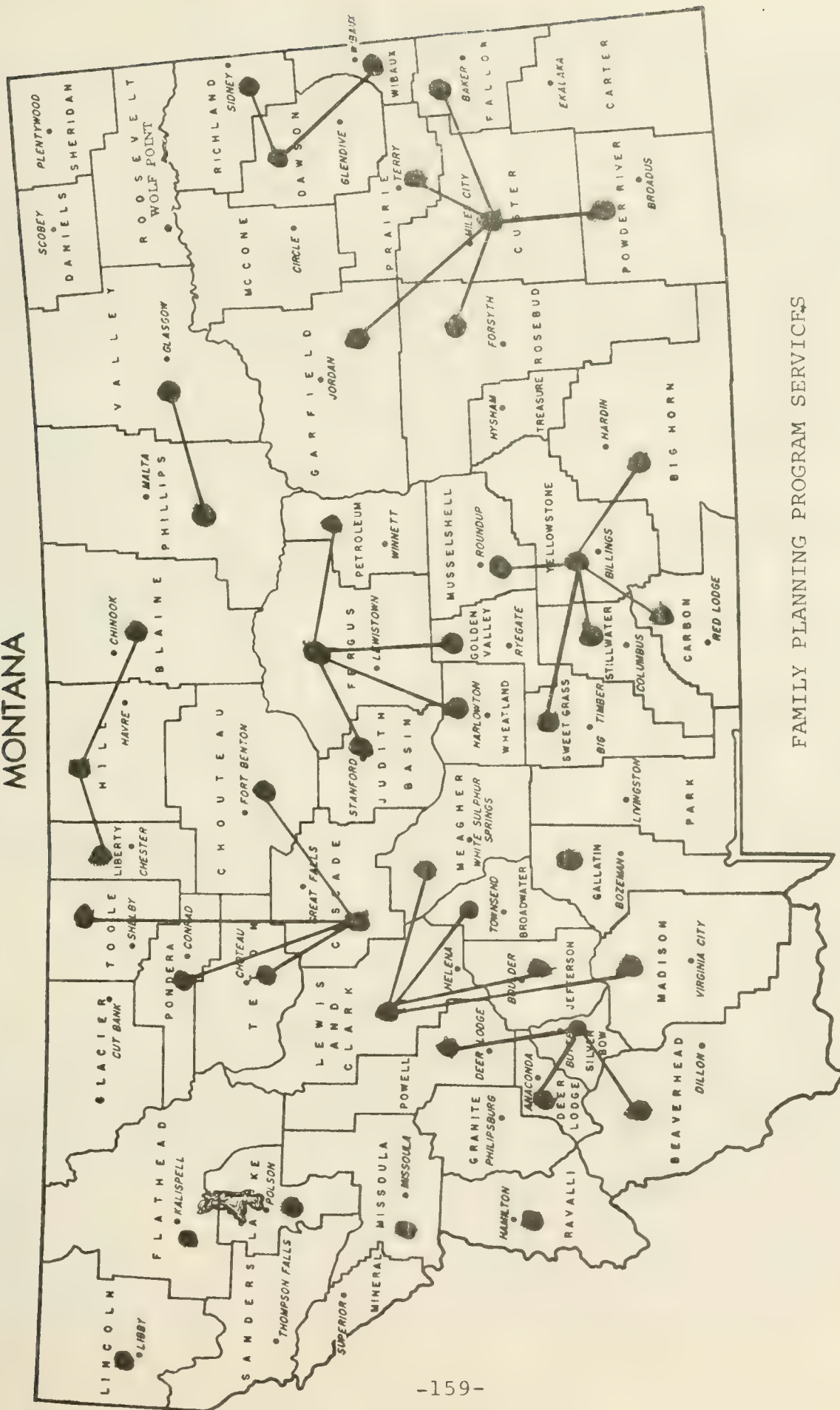
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- Flathead: KALISPELL
- Pondera: CONRAD
- Chouteau: FORT BENTON
- Liberty: CHESTER
- Mill: MAYRE
- Chinook: CHINOOK
- Blaine: BLAINE
- Phillips: PHILLIPS
- Malta: MALTA
- Valley: GLASGOW
- Roosevelt: WOLF POINT
- Daniels: DANIELS
- Scobey: SCOBEE
- Plentywood: PLENTYWOOD
- Sanders Lake: POLSON
- Thompson Falls: THOMPSON FALLS
- Superior: SUPERIOR
- Mineral: MINERAL
- Missoula: MISSOULA
- Powell: POWELL
- Deer Lodge: DEER LODGE
- Granite: PHILIPSBURG
- Hamilton: HAMILTON
- Ravalli: RAVALLI
- Beaverhead: DILLON
- Madison: VIRGINIA CITY
- Bozeman: BOZEMAN
- Gallatin: GALLATIN
- Jefferson: JEFFERSON
- Silver Bow: SILVER BOW
- Butte: BUTTE
- Deer Lodge: DEER LODGE
- Amador: AMADOR
- Boulder: BOULDER
- Melema: MELEMA
- White Sulphur Springs: WHITE SULPHUR SPRINGS
- Wheatland: WHEATLAND
- Harlowton: HARLOWTON
- Golden Valley: GOLDEN VALLEY
- Musselshell: MUSSELSHELL
- Poundup: POUNDUP
- Winnett: WINNETT
- Petroleum: PETROLEUM
- Lewistown: LEWISTOWN
- Fergus: FERGUS
- Stanford: STANFORD
- Judith: JUDITH
- Basin: BASIN
- Great Falls: GREAT FALLS
- Cascade: CASCADE
- Lewis and Clark: LEWIS AND CLARK
- Choteau: CHOTEAU
- Teton: TETON
- Conrad: CONRAD
- Shelby: SHELBY
- Glacier: CUTBANK
- Lincoln: LIBBY
- Flathead: KALISPELL
- Pondera: CONRAD
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- Madison: VIRGINIA CITY
- Bozeman: BOZEMAN
- Gallatin: GALLATIN
- Jefferson: JEFFERSON
- Silver Bow: SILVER BOW
- Butte: BUTTE
- Deer Lodge: DEER LODGE
- Amador: AMADOR
- Boulder: BOULDER
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- Liberty: CHESTER
- Mill: MAYRE
- Chinook: CHINOOK
- Blaine: BLAINE
- Phillips: PHILLIPS
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- Poundup: POUNDUP
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- Petroleum: PETROLEUM
- Lewistown: LEWISTOWN
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- Stanford: STANFORD
- Judith: JUDITH
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- Flathead: KALISPELL
- Pondera: CONRAD
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- Blaine: BLAINE
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CHILD NUTRITION PROGRAM

[illegible]

W. I. C. PROGRAM

# MONTANA



FAMILY PLANNING PROGRAM SERVICES

No. 1052 — County Outline Map  
STATE PUBLISHING COMPANY  
Helena



MONTANA

MCH SPECIAL PROJECTS:

Children & Youth Program  
Helena  
Missoula  
Butte  
Great Falls  
Bozeman  
Billings  
Casper  
Cheyenne  
Cody  
Dillon  
Ekalaka  
Fergus  
Glendive  
Havre  
Jamez  
Kalispell  
Libby  
Miles City  
Missoula  
Park  
Plains  
Polemont  
Red Lodge  
Shelby  
Sidney  
Teton  
Thompson Falls  
Tongue River  
Tulsa  
Valley  
Vernon  
Wendell  
White Sulphur Springs  
Yellowstone  
Zauntee

Children & Youth Program, Helena  
Maternal & Infant Program, Billings  
Teenage Pregnancy Project, Kalispell  
Child Abuse Project, Bozeman  
Well Child Clinics

- 160 -

### Current Goals for the Health Services Division

1. To reduce infant mortality and improve maternal care through special at-risk programs specifically aimed at this segment of the population.
2. To improve the health of Montana children by expanding multi-phasic health screenings, continuing education to local health personnel and additional maternal, infant and child care through special clinics and other special programs.
3. To improve the health of a child with a handicapping condition by providing a multidisciplinary approach for diagnostic evaluations and the management of long term rehabilitation care.
4. To work toward making accessible to all Montana residents comprehensive community health nursing services and to provide continuing education/workshops/training to meet specific agency/nurse needs and objectives.
5. To provide the benefits of a school based preventive program to Montana elementary school children and to provide dental services to 200-500 children of medically indigent families.
6. To maintain or improve the reproductive health of Montana citizens in their reproductive years.
7. To reduce the special risks of pregnant, postpartum and breast-feeding women and their infants and children with respect to their health by reason of inadequate nutrition or health care through the Special Supplemental Food Program.
8. To improve the nutritional status of all infants, children and women in their child-bearing years through provision of nutritional services in all MCH programs.

### Current Objectives for Handicapped Children's Services

1. To increase early outreach, detection and registration of children with handicapping conditions through the following programs: WIC, EPSDT, Well Baby, Newborn Intensive Care Units, and Child Find Project through OPI.

2. To provide comprehensive, multidisciplinary evaluations and coordinated case management through the development of regional centers to the handicapped children eligible and accepted for HCS services.
3. To increase the visibility of HCS so that program services may be utilized by all eligible families.

# SERVICES PROVIDED

TABLE 3.A

Agency: DHES  
Program: MCH

## ALTERNATIVE COMMUNITY LIVING SERVICES

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
Nutritional Services	X			X				

TABLE 3.A

## CASE MANAGEMENT SERVICES - MCH

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-up	Evaluation of Services Provided
1. Health Nurse	X		X				
2. EPSDT	X	X			X		
3. Family Planning	X	X		X	X	X	
4. Nutrition Svs.	X	X	X		X		
5. HCS	X	X	X	X	X	X	
6. Diagnostic Svs.					X		
7. Hearing	X						
8. Disabled Child Program	X						

# SERVICES PROVIDED

Table 3.A

## CHILD DEVELOPMENT SERVICES - MCH

Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
1. EPSDT	X		X	X	X	X
2. Family Planning	X	X	X	X		X
3. WIC					X	
4. Child Nutrition		X				
5. HCS				X		X
6. Health Nurse			X			

TABLE 3.A

## NON/OCATIONAL SOCIAL-DEVELOPMENTAL SERVICE - MCH

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/Day Activities
Nutrition Services	X					

Table 3. A

## MEDICAL SERVICES - MATERNAL & CHILD HEALTH SERVICES

Agency/Service	Diagnostic and Evaluation	Surgery and Treatment	Appliances	Hospitalization	
1. Health Nurse					
2. Family Planning	X			X	
3. Nutrition Services					
4. EPSDT	X				
5. HCS	X	X	X	X	



# NUMBERS OF PERSONS SERVED

Table 3. B CASE MANAGEMENT SERVICES - HANDICAPPED CHILDREN SERVICES\*

TABLE 1																				
REGION	Total Number Served		CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE					
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	219																			
II	286																			
III	307																			
IV	364																			
V	356																			
State-wide	1517																			

\*Figures for persons served available only for Handicapped Children's Services.

Constraints apply to all priority service areas unless otherwise specified:

- HCS:
1. Lack of an evaluation and diagnosis program in Region II.
  2. State distribution of specialists concentrated in a few areas causing constraints in availability of services.
  3. HCS has low public awareness.
  4. No field staff throughout state; all are in State Capital (state department hqs).
  5. Lack of a high risk registry for infants who were in Intensive Care Nursery causing delays in early case finding and services delivery.
  6. Case management services are limited because of staff located in Helena only.
  7. Early detection is limited because of reporting procedures from physicians and lack of procedures for identification of a handicapped child on birth certificates.

## NUMBERS OF PERSONS SERVED

CHILD DEVELOPMENT SERVICES - HCS

[illegible]

MEDICAL SERVICES - HCS

[illegible]

Section 3

MENTAL HEALTH



MENTAL HEALTH AND RESIDENTIAL  
SERVICES DIVISION

In April of 1976, Governor Thomas L. Judge designated the Department of Institutions as the single state authority for the administration and supervision of the Montana Mental Health Program. In this capacity, the Department of Institutions maintains the authority and responsibility for preparation of the State Mental Health Services Plan and for monitoring achievement of the program objectives. Further, this department is accountable to the federal government for correct expenditures of federal funds received for Mental Health administration and program operations under section 314(d) of the Public Health Services Act and for expenditures under Section 227 of the Act.

Primary responsibility for administering mental health services and preparation of the state plan for mental health services rests with the Mental Health and Residential Services Division (MHRSD). The table on the next page is an organization chart for the Division.

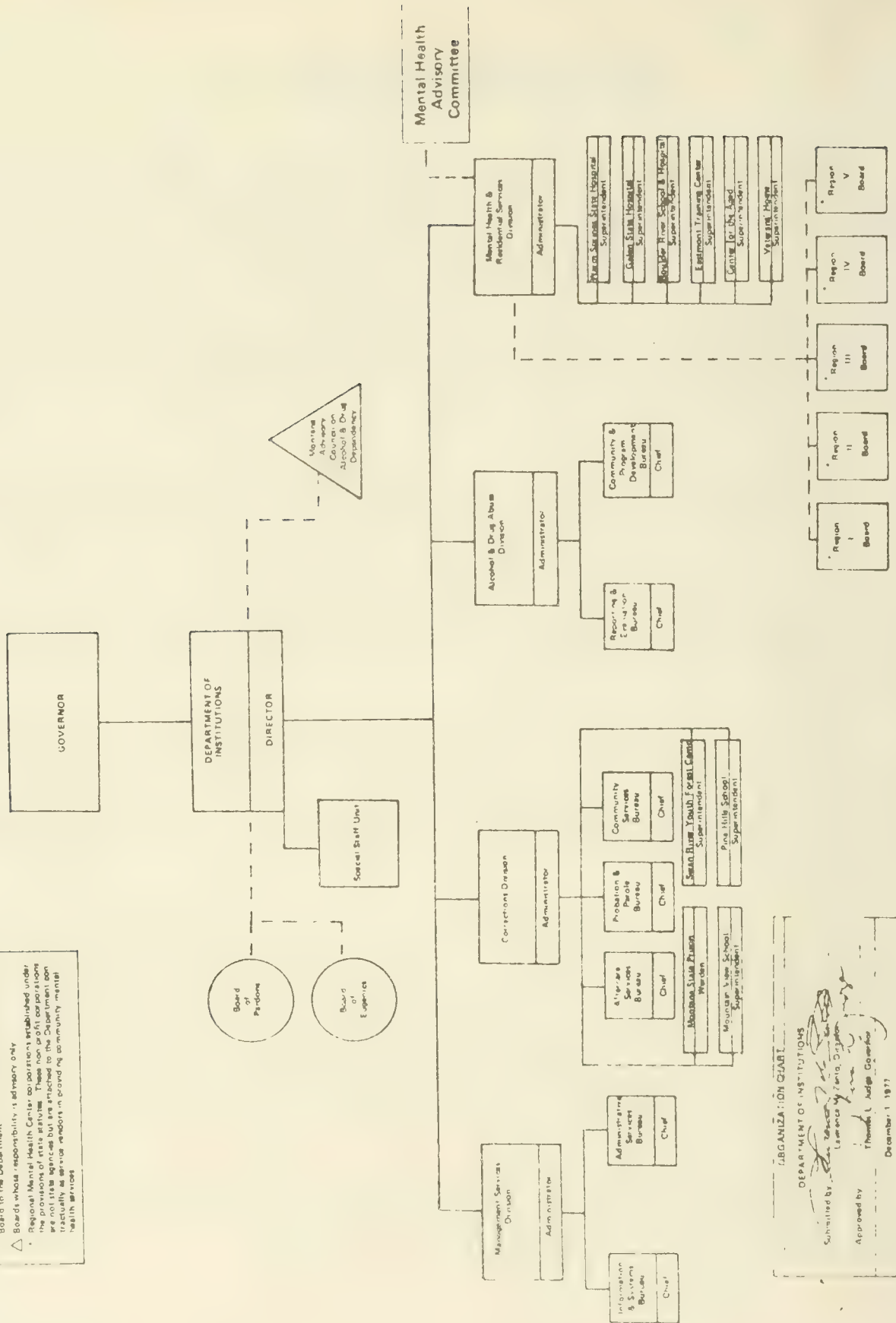
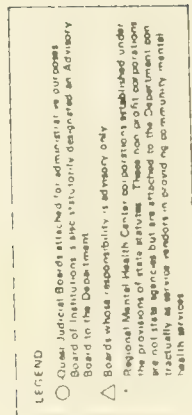
The statutory mission implied in 53-1-201, MCA 1979, for this Division is to rededicate the resources of the state to the productive independence of its now dependent citizens and to promote and maintain the general well-being and mental health of the citizens of this state.

Community mental health services in Montana are provided through five regional private/non-profit community mental health centers, governed by boards of directors composed of county commissioners, representing counties which contribute to local mental health funding, or their designees. The Division contracts with the five regional mental health boards for provision of the services described on the following pages.

Also under the administrative umbrella of the MHRSD are the state custodial institutions which provide services for DD persons, among others. These institutions are: Boulder River School and Hospital and Eastmont Training Center (both for the mentally retarded); Warm Springs State Hospital (for the mentally ill); and Galen State Hospital (housing a small number of mentally retarded patients). The first three institutions above are the subjects of separate subsections of Section 3; a description of the services of Galen State Hospital are contained in this subsection.

Included also in this subsection is a description of the role of the Montana Mental Disabilities Board of Visitors, the statutorily-established advocacy agency for Montana's mental health patients and for institutionalized DD patients.





**ORGANIZATION CHART**  
 DEPARTMENT OF INSTITUTIONS  
 Submitted by: *[Signature]*  
 Checked by: *[Signature]*  
 Approved by: *[Signature]*  
 December 1, 1977

## COMMUNITY MENTAL HEALTH CENTERS (CMHC)

The centers in each catchment area in the state are: Eastern Montana Community Mental Health Center - Miles City; Northcentral Montana Community Mental Health Center - Great Falls; South Central Montana Regional Mental Health Center - Billings; Southwestern Montana Mental Health Center - Helena; and Western Montana Regional Mental Health Center - Missoula.

The map on the next page indicates the locations of the facilities which make up the statewide mental health services system.

### SERVICES PROVIDED BY THE COMMUNITY MENTAL HEALTH CENTERS

#### Inpatient Services

This service is designed to provide a therapeutic environment for persons with severe emotional problems who require 24-hour care. The thrust of inpatient care is to provide short-term, intensive treatment and/or evaluation in a humane manner which promotes and preserves the dignity of the patient. The focus of community mental health center inpatient units is active treatment, short stay, and carefully planned referral to the community with followup care and/or referral to Warm Springs State Hospital (WSSH) if longer-term treatment is required. In general, inpatient service is utilized only when, and for so long as, other center services are not appropriate.

#### Outpatient Services

This is the most widely-used service in the regional mental health centers. It provides the necessary therapies for clients who can be maintained on this basis. Outpatient services are usually provided on a regularly scheduled basis. Clients are seen for non-scheduled visits during times of increased stress or crisis. Thirty-four offices are available on a fulltime basis throughout the state. Where resident satellite offices are not available, traveling staff members from neighboring counties visit once or twice a week.

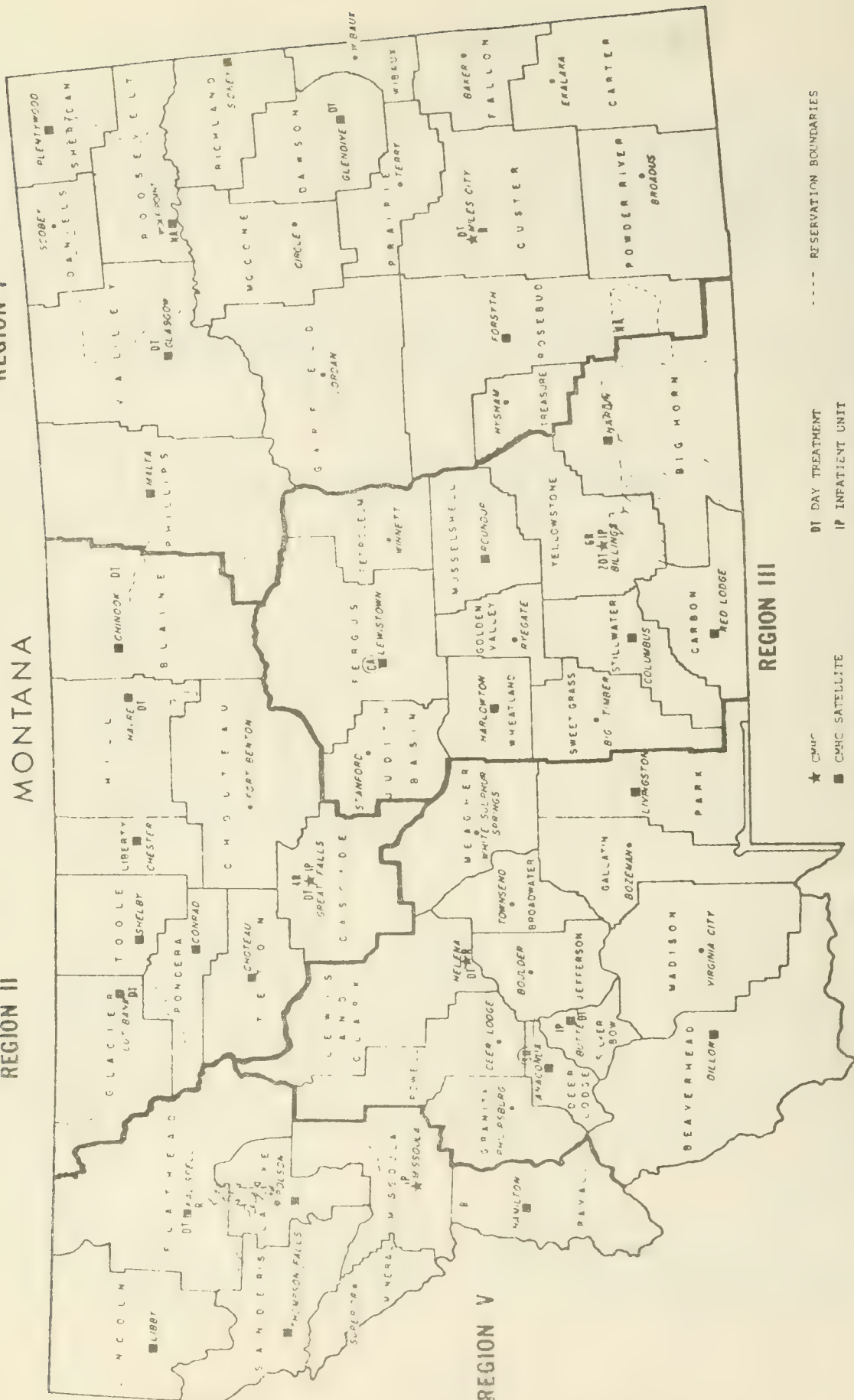
#### Emergency Service

This service provides immediate health care and evaluation for persons in crisis on a 24-hour-a-day, seven-day-a-week basis. The regional mental health centers have a mental health professional on call for either consultation or direct service, as needed.

REGION I

MONTANA

REGION II



DT DAY TREATMENT  
 IP INPATIENT UNIT  
 R RESIDENTIAL FACILITY  
 NA NATIVE AMERICAN OUTPATIENT WORKER

★ CMHC  
 ■ CMHC SATELLITE  
 SR STATE HOSPITAL  
 CA CENTER FOR THE AGED

The more populated communities have crisis telephone service manned by trained workers and/or staff members of the mental health center. A list of mental health professionals who are on call are available to the workers on the crisis telephone.

### Day Treatment and Other Partial Hospitalization Services

The five Regional Mental Health Centers are currently providing day treatment services for persons with acute and long term mental health problems. Persons in day treatment may have been discharged from WSSH, private hospitals, or referred by other services of the mental health centers or other community agencies.

Day treatment services is designed to provide a therapeutic program for those persons who require less than 24-hour a day care, but more than out-patient care. This service has proven to be an effective transition between fulltime care and return to the community in Montana.

There are 13 day treatment facilities available in Montana with services offered from 20-40 hours per week and open 3-5 days per week.

### Consultation and Education

This service is provided across the state. The Regional Mental Health Centers are providing some consultation and education to schools, courts, law enforcement agencies, and health services delivery agencies. The Montana Association for Mental Health does address the general public on the nature of mental health problems and types of services available but suffers from insufficient chapter development to cover all parts of Montana.

The Mental Health Association of Montana is a volunteer organization concerned with improving the mental health of citizens of Montana. The Association is part of a three-level structure which is composed of the National Association for Mental Health, State Associations and local chapters. The state association is located in Helena. There are currently 12 local chapters of the Association in Montana.

### Specialized Services for Children

In addition to the Children's Unit at WSSH, children have always received care at Regional Mental Health Centers. However, due to the specific nature of their needs and specialized training needed to provide services, greater attention should be paid to programs for children.

One new program operative in Region II, the Adolescent Residential Treatment Unit (RITZ), places a priority on accepting children from child study teams across the state who have been declared educationally handicapped as a result of emotional disturbances. The RITZ provides ten beds to meet the need around the state. In addition to providing a therapeutic milieu of treatment approaches, a strong individualized educational component is established.



There are other special programs for children with emotional problems that have been federally funded in two of the five regions. Region III has a children's grant to provide consultation and education to schools, day care services for children, and group therapy for parents. Outpatient services for children are available in all five Mental Health Center central offices and 28 satellites, and workers skilled and experienced in children's work are employed. The centers do have children's specialists who are assigned responsibility for managing the children's programs.

A full range of programs are needed to serve children who are: abused and/or neglected; psychotic, acting out; or are suffering from emotional disturbances or organic disorders.

There is one private residential home for children with emotional problems in the state located in Billings.

The Community Mental Health Centers Act of 1975 stresses that a regional mental health center must devote a meaningful portion of its resources to addressing the needs of children. Services for children should include the full range of services made available by the center, appropriately geared to the needs of children at different stages of development. There is need for extensive coordination and collaboration with children's agencies and services throughout the state.

#### Specialized Services to Elderly

Programs for the elderly should address the full range of diagnostic, treatment, liaison, and followup services. Since, for many elderly, opportunities for social contact are restricted, it is particularly important that followup services be carefully planned and implemented with the aim of maintaining therapeutic gains and reducing the impact of isolation. As many elderly citizens have little knowledge and awareness of mental health programs and very seldom voluntarily seek out services, an extensive mental health education thrust is necessary to adequately involve this segment of society.

Many elderly patients are being deinstitutionalized. The Regional Mental Health Centers are responsible for their placement and treatment. This service has been funded in the past from a contract between the Department of Institutions and the Regional Mental Health Centers. There are few formalized programs specifically for the elderly, other than placing inappropriately housed patients from WSSH into nursing homes, but most centers do provide transportation, include patients in day treatment and consult with nursing homes. There is a beginning attempt to assign specific responsibilities to one person in the center and a plan of action drawn up.



## Transitional Services (Community-Based Residential Treatment Facilities)

All five catchment areas within the state have transitional and/or group home care facilities, with two in Region V, one in Region IV, four in Region II, six in Region III and one in Region I. This is an increase of two over the total in 1979. Further development of this service is an urgent priority to maintain continuity of care for discharged institutional patients. New resources need to be developed in communities to provide the very important transitional homes. It is a fact that many patients would not have to live in WSSH if alternate living accommodations could be located near treatment services.

A variety of forms of transitional care has developed in Montana. Region III operates three group homes in conjunction with a local hospital, and has two community cluster homes for more independent living. With the stimulus of the Mental Health Community Support Project, this center has recently developed an apartment cluster home for living arrangements more independent than the two previously mentioned facilities. In Region V, an independent boarding home is contracting with the mental health center and providing care for five deinstitutionalized patients. A new group home opened in Kalispell in 1978. In Region II, the center has an agreement with the Salvation Army to provide care for 15 deinstitutionalized patients. In addition, a local hotel is working closely with the center and providing care for five patients. A new group home and apartment cluster opened in 1978-79. Region IV has its own transitional home. Region I has a transitional home adjacent to the general hospital. All of the regions are consulting with those private nursing home facilities which have taken patients from WSSH, and provide direct service as requested.

## Followup Care for the Chronically Mentally Ill

The State Mental Health Authority is required to provide assistance to the Regional Mental Health Centers to facilitate followup care and/or follow along for residents who have been discharged from mental health facilities. This requirement is designed to assure adequate community support for those no longer in need of inpatient care or day treatment, with particular emphasis on the needs of patients discharged from WSSH.

The State Department of Social and Rehabilitation Services has been involved in placements in nursing homes. Other community referral mechanisms are also utilized. The case management system is interlocked with the formal treatment plan and facilitates the treatment, rehabilitation, social and domiciliary needs being adequately addressed for each discharged patient from WSSH. There are, however, differing concepts as to case management among regions. Evaluation and monitoring of the service is accomplished by the MHRSD.

## Minorities Services

See Section 7, Special Programs, for information on mental health services available to Montana's Indian population.

## Rape Services

Prevention of rape and services to victims of rape is mandated by P.L. 94-63. In four of Montana's mental health regions, volunteer organizations have been developed and the centers do consult with and provide training to them and assist as needed. In Region I, where no such agency exists, the center has an on-going relationship with the police who do call and refer as needed for services.

## CURRENT GOALS AND OBJECTIVES FOR THE MENTAL HEALTH SYSTEM

GOAL I: The MHRSD shall maintain leadership in the orderly integration of a statewide service delivery network.

Objective 1: To establish a mental health advisory committee to the MHRSD.

Objective 2: To maintain and broaden an advisory committee to the Community Support Project.

Objective 3: To develop formal, written agreements that delineate specific agency responsibilities for provision of services in areas of overlapping statutory responsibility among state agencies.

Objective 4: To develop a written document that clearly delineates the roles and responsibilities of the MHRSD, each institution and the community mental health programs.

Objective 5: To develop a comprehensive service delivery plan for the developmentally disabled that identifies needs and appropriate living environments for all developmentally disabled.

Objective 6: To develop for each institution and CMHC a Management by Objective Plan for FY 81.

GOAL II: To promote and provide high quality services within state administered and private programs which emphasize the following population groups: long term care populations; children; elderly; rural populations; and American Indians.

- Objective 1: To participate in planning and conducting one statewide training event that focuses on the specific needs of each special population group.
- Objective 2: To assist the CMHCs in applying for technical assistance grants from the HEW regional office centered around management concerns for three or more special population groups.
- Objective 3: To assist relevant private advocacy groups in presenting or supporting appropriate legislation on behalf of each population group.
- Objective 4: To initiate two interstate (regional) programs or activities on behalf of each population group.
- Objective 5: To collaborate with other agencies and develop a policy of placement for long term care DD people by August 15, 1980.
- Objective 6: To develop a written assessment of current community resources for seriously emotionally disturbed children to identify service gaps.

Goal III: To continue to implement Montana's deinstitutionalization policy for the mentally ill and developmentally disabled. The policy is predicated upon: promotion of prevention services at the community and institutional levels; provision of quality services within institutions for those appropriately requiring such services; and community placement of inappropriately institutionalized persons through development of quality community support systems for after-care.

- Objective 1: To conduct, sponsor or co-sponsor at least one training event at each institution.
- Objective 2: To create a staff development plan for the CMHCs and for each mental health institution in the state.
- Objective 3: To plan, develop and implement a recommended professional persons' certification law which will provide the framework for licensure of mental health professionals in Montana.
- Objective 4: Within the limits of resources available, to provide an appropriate education for all schoolaged residents at each institution.
- Objective 5: To reduce inappropriate placements among the institutional population by 15%



Objective 6: To develop, implement and monitor a working agreement between WSSH and the CMHCs by use of quarterly meetings between the direct service providers.

Objective 7: To develop a specific plan and timetable to transfer those prisoners who are inappropriately placed at the prison to the Forensic Unit at WSSH; develop three alternatives to the present Forensic Unit for presentation to the 1981 Legislature; and in cooperation with the Corrections Division of the Department of Institutions, identify the prison population in need of intensive treatment.

Goal IV: To provide unified, comprehensive services which include quality of care standards, are based on client needs, are cost effective and accountable, and are evaluated.

Objective 1: To develop a uniform statistical reporting system to be used by all institutions, such system to be compatible with CMHC formats.

Objective 2: To coordinate all agency reviews of community mental health and institutional programs in order to reduce duplication and inefficiency.

Objective 3: To influence the development of increased para-professional utilization and training.

Objective 4: To conduct a site assessment of each CMHC during FY 80.

Objective 5: To review all budgets with the respective institution at least 30 days prior to being presented to the Legislature.

Objective 6: To develop a plan for increasing the number and quality of group home spaces available in the state.

The following pages contain information about four of Montana's five Regional Community Mental Health Centers. No information is available from Region I, the Eastern Montana Community Mental Health Center.

Tables 3B at the end of this subsection, relating to persons served by the community mental health system, also contain figures only for the programs of Regions II, III, IV and V.

NORTHCENTRAL MONTANA COMMUNITY MENTAL HEALTH CENTER

(REGION II)

Regional Goals and Objectives:

Although the Center is committed to developing specialized programs for some target groups, it did not plan any major program expansion for fiscal year July 1, 1979 to June 30, 1980, except for the addition of an adolescent residential treatment unit (The "RITZ" - see page ). The goals and objectives for the next fiscal year are as follows:

Goal I: Increase center financial security

Objective 1: Increase the number of service contracts with other government agencies and/or the private sector.

Objective 2: Increase staff direct service time.

Objective 3: Develop more productive billing procedures.

Goal II: Improve treatment programs for specific target groups.

Objective 1: Develop satellite office on Blackfeet Indian Reservation.

Objective 2: Increase consultation visits to nursing homes.

Objective 3: Maintain coordination efforts with programs that provide chemical dependency treatment.

Objective 4: Develop liaison personnel between center staff and Cascade County Indian population.

Objective 5: Survey clinical reports for rape victims, spouse abuse and child abuse.

Goal III: Insure Quality Care

Objective 1: Continue use of UPR and expand when needed.

Objective 2: Develop more use of the Professional Advisory Board in regard to program and staff development.

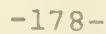
Objective 3: Initiate clinical staff meetings in all major units.



Ms. A.9.2.1.6

Table of Organization &amp; Staffing

August 1979



The Northcentral Montana Community Mental Health Center's first commitment is to retain high professional quality of mental health services to people in our region. To that end, the endeavor is to hire top-rate personnel in all areas, upgrade their abilities, and monitor service delivery with peer, record, and utilization review systems.

After five years of Center operations, most of our programs are in place. There will be some adding of programs such as senior citizens, Native Americans, and spouse abuse victims.

Our overall efforts will be for greater quality and efficiency in all Center operations, so as much quality service as possible will be obtained from each dollar.

#### SOUTH CENTRAL MONTANA REGIONAL MENTAL HEALTH CENTER\*

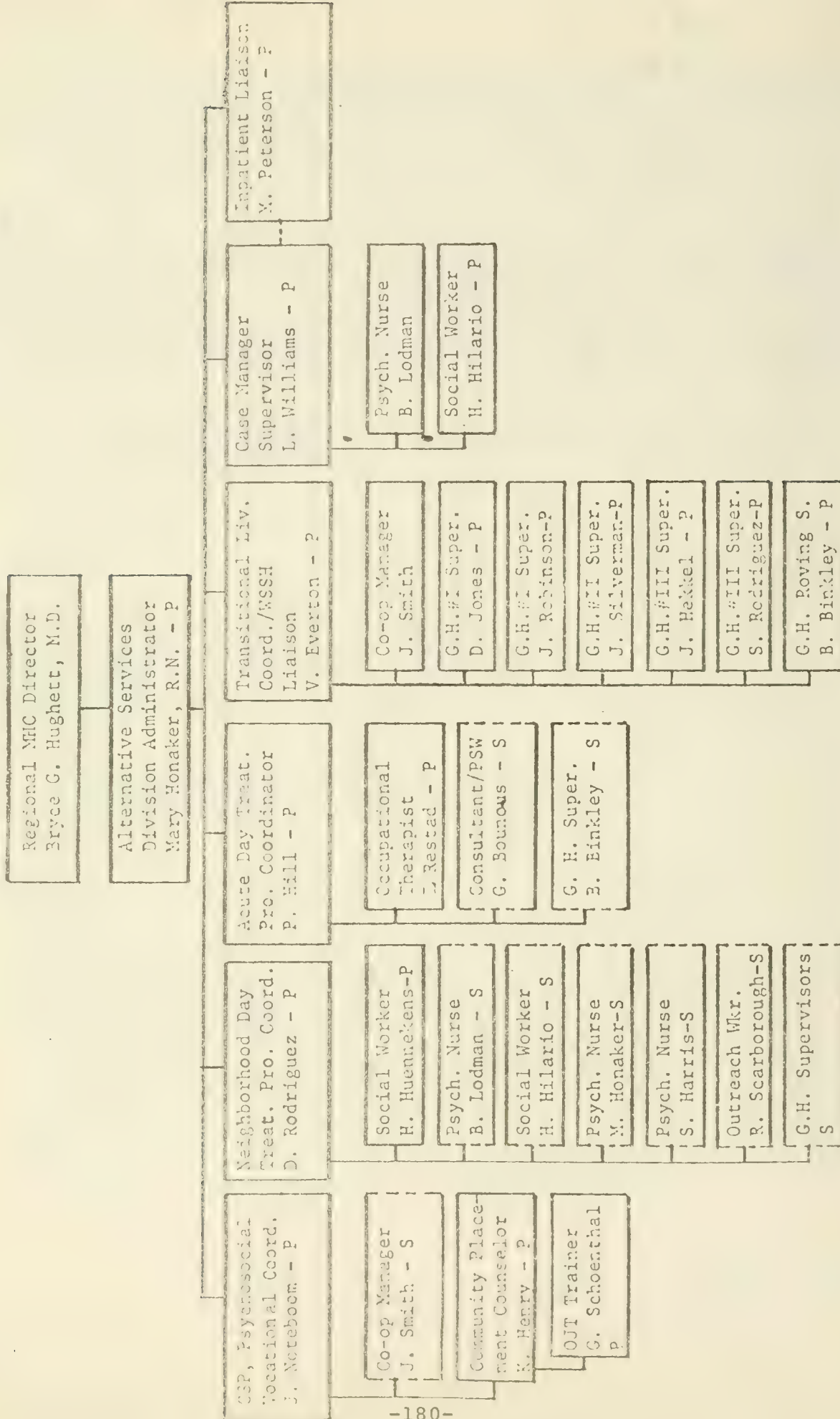
(REGION III)

#### Current Goals and Objectives:

- GOAL I: Identification of chronically mentally ill persons to prevent such patients from being lost from the system and becoming more ill than they need be; also, identification of these patients to ensure that they receive appropriate ongoing services.
- GOAL II. Provision of an acceptable and available range of services in the community for chronically mentally ill patients so that these patients will be maintained in the least restrictive environment that is appropriate.
- GOAL III: Coordination with other service providers so that a full range of service levels will be available for and utilized by the chronically mentally ill.
- GOAL IV. Maintenance of ongoing effective case management of the chronically mentally ill to ensure that these patients are being served in the most appropriate environment.
- Objective 1: Continue identification of the chronically mentally ill on the Center's caseload (Goal I).
- Objective 2: During FY 1981 seek to maintain as much as possible deinstitutionalization gains of past years by stabilizing the FY 81 admission numbers to 75-85 (Goal II).

\*Plan for Treatment of Chronically Mentally Ill only.

# ALTERNATIVE SERVICES DIVISION



P - Primary Responsibility  
S - Secondary

- Objective 3: Maintain outreach to potentially underserved, at risk populations (Goals II and IV).
- Objective 4: During FY 81, Alternative Services Division will utilize trained volunteer case managers for at least 30-45 cases (Goals II, III and IV).
- Objective 5: During FY 81, Alternative Services Division will hold educational programs with affiliated and related agencies through which four to six of 24 agencies will be given presentations on mental health services for chronically mentally ill patients (Goal III).
- Objective 6: To insure that, in cases in which patient cooperation and other factors make the services appropriate, needed and recommended case followup services are actually delivered and documented by staffing notes.
- Objective 7: During FY 81, the Center's Community Placement Service will find employment for unemployed chronic patients when employment is appropriate (Goal II and III).
- Objective 8: Group home patients will be monitored and moved from more to less restrictive settings as soon as appropriate and possible (Goal II).

SOUTHWEST MONTANA MENTAL HEALTH CENTER

(REGION IV)

Current Goals and Objectives:

- Goal I: To improve coordination of aftercare service efforts, prevent waiting lists in outpatient care and reduce case record deficits in the Helena Satellite Office by October 1, 1980.
- Objective 1: To hire, by July 1, 1980, a master's level aftercare coordinator to devote fulltime to the coordination of the after-service of the Helena Satellite office.
- Objective 2: To have coordinated all of the elements of the Helena Satellite aftercare program under the after-care coordinator by October 1, 1980.
- Objective 3: To maintain a policy of furnishing lists of cases not receiving services in ninety days to all satellite offices.

Goal II: To develop a plan for conducting a needs assessment for the Region by October 1, 1980.

Objective 1: To initiate a survey of community agencies as part of the needs assessment by October 1, 1980.

Objective 2: To have results of the needs assessment available to the Governing Board, Advisory Boards and other community groups and agencies by January 1, 1981.

Goal III: To provide to the Governing Board, Advisory Boards and staff a cost analysis of each program and satellite office by January 1, 1981.

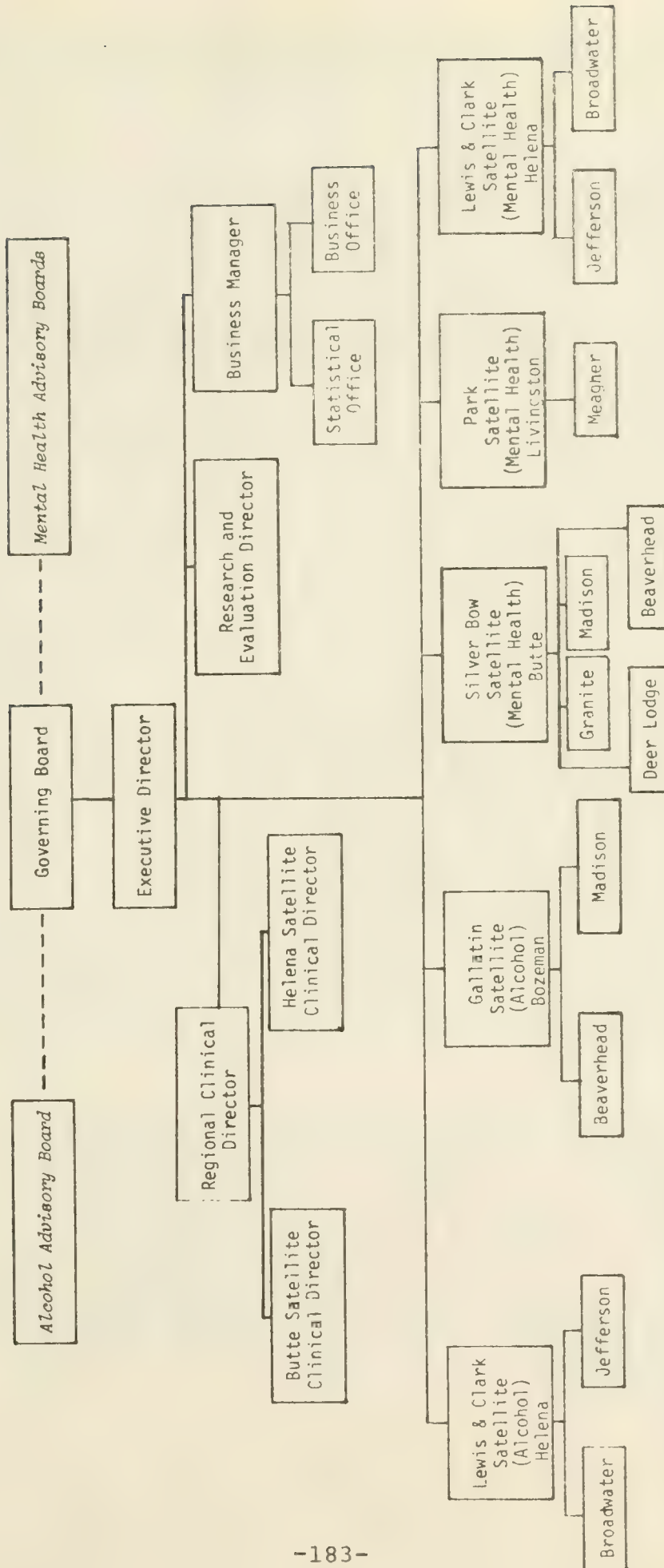
Objective 1: To have all financial data subsystems on the computer by October 1, 1980.

Objective 2: To have cost finding analysis complete by December 1, 1980.



# SOUTHWEST MONTANA MENTAL HEALTH CENTER

## ORGANIZATION CHART



WESTERN MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER  
(REGION V)

Current Goals and Objectives:

GOAL I: To insure the provision of those essential services mandated by federal law and state contract.

Objective 1: Quarterly review of essential services by office directors, administrative staff and designated program coordinators, culminating in an annual report.

Objective 2: Contract or affiliate with existing community programs which fulfill essential service requirements.

Objective 3: Ongoing survey of comprehensive services provided in the community which are not provided by the Center.

GOAL II: Emphasize preventive services in program planning.

Objective 1: Obtain a mental health educator.

Objective 2: Establish a regional resource center for preventive activities and materials.

GOAL III: Maintain and enhance community support systems for the chronic psychiatric population residing in Region V.

Objective 1: Clarify roles and responsibilities of regional aftercare staff.

Objective 2: Research locations, living conditions and source of income of present aftercare population.

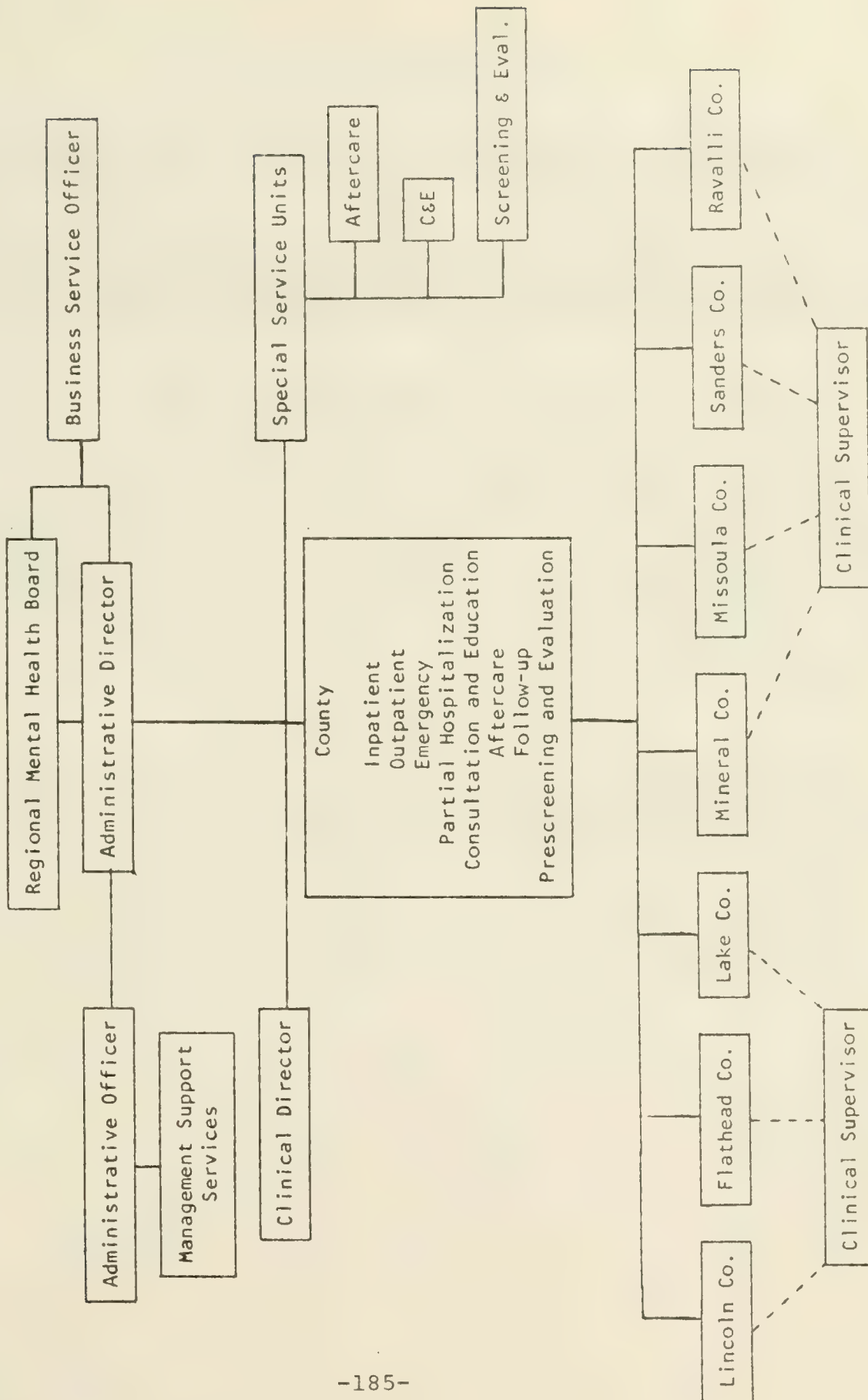
Objective 3: Investigate potential locations of Day Care programs.

GOAL IV: To upgrade service delivery by increasing the staff to population ratio to commonly accepted professional standards.

Objective 1: Executive Director and Administrative Officer will establish presently accepted standards.

GOAL V: To provide increased services to underserved populations in our catchment area - specifically, children, elderly, and minorities.

WESTERN MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER  
ADMINISTRATIVE STRUCTURE



## GALEN STATE HOSPITAL

Galen State Hospital (GSH) provides services for severely medically involved mentally retarded patients. Referrals to this facility are very infrequent. However, at the current time, GHS serves six mentally retarded persons, who require 24-hour per day medical supervision. In addition to medical services, these patients receive physical therapy and recreational services as prescribed by the physician's treatment plan.

## COMMUNITY SUPPORT PROJECT

A major thrust of the MHRSD Community Support Project is to expand and increase followup care. Utilizing South Central Mental Health Center as a core service agency, a demonstration model has been developed and will continue to be refined for use throughout the state. Expanded program development started with Region I on July 1, 1979, followed by Regions II and V on July 1, 1980 and Region IV on July 1, 1981.

## MENTAL HEALTH MANPOWER PROJECT

For information about the MHRSD Manpower Project, see Section 6 of the Plan. This project is the training component for the Montana mental health system.

## MENTAL DISABILITIES BOARD OF VISITORS

The Board of Visitors is the quality assurance agency for the commitment and treatment acts for the mentally ill and the developmentally disabled, and has been statutorily established in Montana law (2-15-211, MCA 1979).

The Board's purpose is to assure that the treatment of all persons voluntarily admitted or involuntarily committed to a mental health facility or an institution for the mentally retarded is humane and decent and meets the standards established by law.

The Board makes an inspection of every mental health facility within the state providing evaluation and treatment for mentally ill persons. The Board also performs site visits to the two institutions for the mentally retarded. The following facilities are inspected by the Board of Visitors: the five Community Mental Health Centers and their satellites, Warm Springs State Hospital, Boulder River School and Hospital, Eastmont Training Center, Montana Center for the Aged, and Galen State Hospital. An average of 12 site visits per year are made by the Board. These inspections include overviews of the physical plants, including residential and treatment areas, and inquiries into general and individual treatment plans being used in the facilities. The Board of Visitors assists residents at the facilities to resolve any grievances they may have concerning their commitment or course of treatment.

If the Board of Visitors determines that a facility is failing to comply with the requirements of state law in regard to its physical plant, or the care or treatment of residents, the Board reports its findings to the next of kin or guardian of the patient involved, the responsible person appointed by the court for the patient involved, the professional person in charge of the facility, the director of the Department of Institutions, and the district court which has jurisdiction over the facility. The Board makes an annual report to the Governor and reports to each regular session of the Montana Legislature.

The Board has one staff person to assist it in carrying out its duties.





SERVICES PROVIDED

TABLE 3.A

ALTERNATIVE COMMUNITY LIVING SERVICES

**Agency:** Mental Health System  
**Program:** Regions II, III, IV, & V

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
Halfway Houses or Transitional Homes	X			X			X	X

Tables 3A concerning services provided indicate services available statewide through the Montana Community Mental Health System and are based on information supplied by the MHRSD of the Department of Institutions.

Tables 3B concerning numbers of persons served within these service categories relate to services provided only by the Western Montana Community Mental Health Center, the North-central Montana Community Mental Health Center, the Southwest Montana Community Mental Health Center, and the South Central Montana Community Mental Health Center.

1  
1  
88  
8  
1

SERVICES PROVIDED

TABLE 3.A

CASE MANAGEMENT SERVICES

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
Inpatient Services					X		
Emergency Services	X				X		
Services to Children & Elderly	X		X			X	
Aftercare Services						X	
Screening & Diag			X				
Consultation & Eval	X	X	X				
Alcohol & Drugs	X	X	X	X		X	

SERVICES PROVIDED

TABLE 3.A

CHILD DEVELOPMENT SERVICES - Mental Health						
Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
Out-patient Service		X				
Emergency Services		X				
Services to Children & Elderly	X	X	X	X		X
Aftercare or Followup		X				
Screening & Diagnosis	X		X	X		

SERVICES PROVIDED

TABLE 3.A

NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE						
Service	Assisting with Daily Living	Transport- tation	Financial Assistance	Recreation	Training in Personal/Social/ Civic Matters	Work/Day Activities
Transitional or Halfway House	X	X			X	X
Alcohol & Drugs					X	

Table 3.B

ALTERNATIVE COMMUNITY LIVING ARRANGEMENT SERVICE - Mental Health

REGION	All Services	CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			
		TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	
I																	
II		2682															
III		3085															
IV		2964															
V		2290															

Constraints, which apply statewide to all priority service areas, are as follows:

The MHRSD has outlined six major priorities for mental health programs. They are services to:

- the chronically mentally ill
- children
- the elderly
- the unserved and underserved
- the acutely mentally ill

There is also a need for increased consultation, education and prevention services designed to promote the mental health of all citizens and a need for improved manpower development and training programs to insure quality mental health care for those who seek or require it.

A statewide shortage of psychiatrists hampers services.

The rural nature of the state makes service delivery difficult in rural areas.

More community residential (transitional) facilities are needed.

# NUMBERS OF PERSONS SERVED

## CASE MANAGEMENT - Mental Health

REGION	TOTAL	CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE	
		YES		NO		YES		NO	
		DD	TOTAL	DD	TOTAL	DD	TOTAL	DD	TOTAL
I	2682								
II	3085								
III	2694								
IV	2290								
V									

# NUMBERS OF PERSONS SERVED

## CHILD DEVELOPMENT SERVICE - Mental Health

REGION	TOTAL	CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE	
		YES		NO		YES		NO	
		DD	TOTAL	DD	TOTAL	DD	TOTAL	DD	TOTAL
I	2682								
II	3085								
III	2964								
IV	2290								
V									



# NUMBERS OF PERSONS SERVED

Table 3. B NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES - Mental Health

REGION	All Services		CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE					
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I																				
II	2682																			
III	3085																			
IV	2964																			
V	2290																			

TABLE 3.A

## SERVICES PROVIDED

TABLE 3.A		CASE MANAGEMENT SERVICES				Agency: Department of Institutions	
		Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Program: Galen State Hospital
Service							
All Services				X	X	X	X

TABLE 3.A

## NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/Day Activities
Recreational Services				X		

Table 3. A

## MEDICAL SERVICES

Service	Adult Diagnostic and Evaluation	Surgery and Treatment	Appliances	Hospitalization	Physical Therapy
Physical Therapy			X		X
Other Medical Services	X	X		X	

## Table 3.13

Table 3.13

## CASE MANAGEMENT SERVICES - GALEN STATE HOSPITAL

[illegible]

-194-

Table 3. B

## MEDICAL SERVICES

[illegible]

100

## Table 3.13.

Institution

Section 3

PUBLIC ASSISTANCE/MEDICAL ASSISTANCE





## PUBLIC ASSISTANCE

Under State Law (53-4-203) the State Department of Social and Rehabilitation Services, through the Economic Assistance Division (EAD), is charged with the responsibility of administering the Aid to Dependent Children (ADC) Program. The law further specifies that the program shall be uniform throughout the counties of the state and shall be supervised and administered at the local level through the county departments of public welfare. See the map on the following page for locations of the county departments of public welfare in the state.

The law further specifies that, for purposes of public assistance, the term "dependent child" means: a) a child under the age of 18; or b) a person under the age of 21 who is a student under the administrative rules governing the program. Further, the child must be deprived of parental support or care and must be living with one of several specified relatives. The statutory purpose of ADC payments is twofold: a) to pay for medical care on behalf of a dependent child; and/or b) to meet the monthly needs of a relative with whom the child is living.

Administrative rules governing the program are developed by the EAD. Eligibility and the amount of the payment are determined by a County Board of Public Welfare, according to the provisions of the state administrative rules. Most county boards of public welfare are comprised of the county commissioners.

The county's share of the program is an amount equal to 22.5% of the amount of the ADC payment, exclusive of the federal share.

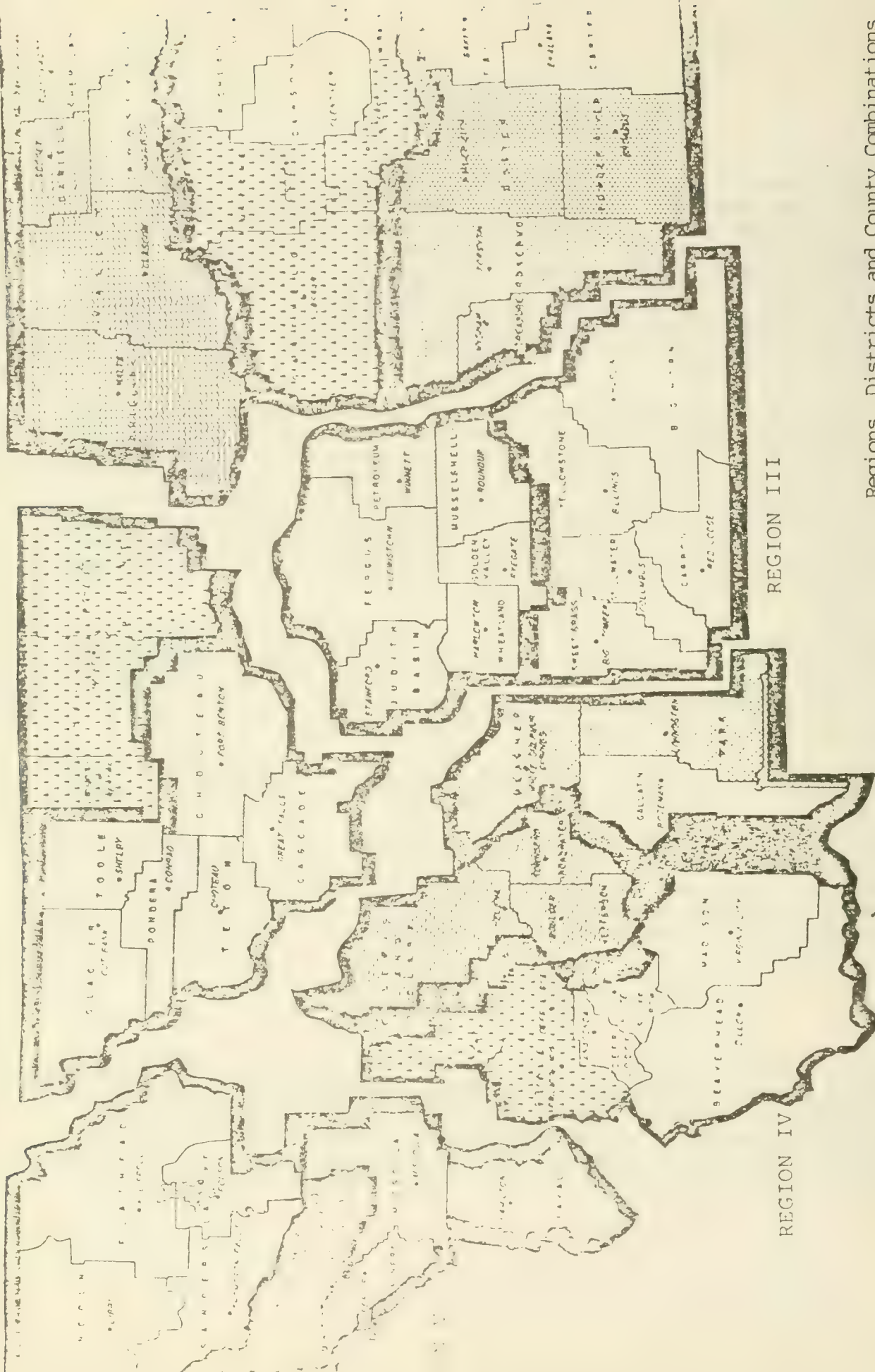
A unique provision in Montana law states that ADC payments on behalf of Indian children may not be affected by funds received by that child's family as enrolled members of an Indian tribe or by per capita payments to tribal members or by a share in the profits and receipts from tribal lands and interests or tribal enterprises.

## MEDICAL ASSISTANCE

Again, State Law (53-6-111) charges the Department of Social and Rehabilitation Services with general administration of the Medical Assistance Program authorized under Title XIX of the Social Security Act (Medicaid), and county departments of public welfare are charged with local administration of the Program. This Program, too, comes under the purview of the Economic Assistance Division.

REGION I

REGION II



Regions, Districts and County Combinations  
for Welfare Administration

Unshaded Counties Are Separately Administered

Medical Assistance benefits pay for all necessary inpatient and outpatient medical services, and, on an optional basis, may include such ancillary services as eyeglasses, dentures, home health care, etc. The range of optional benefits is limited by the amounts of money made available for the Program by the State Legislature each biennium. If funds run short during the biennium, SRS is authorized to prioritize the benefits available.

Administrative Rules governing the Program are developed by the EAD, and again, the County Board of Public Welfare determines eligibility. Recipients of Supplemental Security Income are automatically eligible for Medical Assistance benefits.

Eligibility criteria specify that all persons who reside in the State, including residents temporarily absent from the State, are eligible for Medical Assistance benefits if they meet the following requirements:

- a) receive all or part of their income from the federally aided public assistance programs: old-age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled;
- b) upon application, would be eligible for financial assistance under any one of the federally aided programs referred to above;
- c) would be entitled to financial assistance under one of the federally aided categories except that they do **not** meet the durational residence requirements or relative responsibility requirements of any of the public assistance programs above enumerated;
- d) are in medical institutions and if they were no longer in such institution would be eligible for financial assistance under one of the above programs;
- e) are under 21 years of age and meet the conditions of eligibility in the state's plan for aid to dependent children, other than with respect to school attendance;
- f) are under 21 years of age and in foster care under the supervision of the state;
- g) have income less than 133 1/3% of the amounts specified as maximum income levels for federally aided categories of assistance;
- h) are under 21 years of age and medically needy, as defined by the department of SRS; or
- i) are under 21 years of age, were in foster care under the supervision of the state, and have been adopted as "hard-to-place" children.





SERVICES PROVIDED

Service	CASE MANAGEMENT SERVICES				AGENCY: SRS	
	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-up Along
Public Assistance Program	X	X	X	X		

SERVICES PROVIDED

Service	CASE MANAGEMENT SERVICES				AGENCY: SRS	
	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-up Along
Medical Assistance Program	X	X	X	X		

# NUMBERS OF PERSONS SERVED

Table 3.3 CASE MANAGEMENT - PUBLIC ASSISTANCE

REGION	ADC		CAPACITY FOR MORE			Food Stamps		CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL
I	1704					2272										
II	2232					2976										
III	2412					3216										
IV	2856					3808										
V	2796					3728										
State-wide	12,000					16,000										

1. Totals indicate total services provided per MONTH.
2. There is no information available separating the DD population served from all persons served.
3. Constraint applies to both services:  
Inadequate fiscal resources to provide recipients a decent standard of living.

Table 3. B

## CASE MANAGEMENT - MEDICAL ASSISTANCE

REGION	All Services Provided	CAPACITY FOR MORE				CAPACITY FOR MORE				CAPACITY FOR MORE				CAPACITY FOR MORE							
		TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	4564																				
II	5972																				
III	6420																				
IV	7604																				
V	7440																				
State- wide	32000																				

1. Totals indicate total services provided per MONTH.
2. There is no information available separating DD population from all persons served.
3. Constraint to services: Some providers are reluctant to provide full range of services because Medicaid program pays fees which are much below the medical fees paid by the general public.



### Section 3

#### REGIONAL DEVELOPMENTAL DISABILITIES COUNCILS





## REGIONAL DEVELOPMENTAL DISABILITIES ADVISORY COUNCILS

This section deals with Montana's Regional Developmental Disabilities Advisory Councils. Included are the statutory and administrative rule requirements for the function and structure of the regional councils and their roles and responsibilities as they jointly perceive them pursuant to their statutory mandate. Also included are the regional council's goals and objectives which have been extracted from their regional plans.

It should be emphasized that the regional councils' principal function is to advise the Developmental Disabilities Division of SRS and to plan for the same groups of DD persons as the Division serves, i.e., the mentally retarded, cerebral palsied, epileptic and autistic.

The DDD maintains regional offices in the locations indicated on the map on the following page. The Regional Supervisors in each of these offices provides staffing for the activities of the regional councils.

No Tables 3.A or 3.B showing availability of services or numbers of persons served are included in this section, since regional council figures would duplicate the figures shown in the DDD section.

The "Montana Developmental Disabilities State Law" (53-20-207, M.C.A., 1979) mandates the following:

"53-20-207. Regional councils. (1) The department shall approve a citizens' organization as a regional council for each of the following five regions:

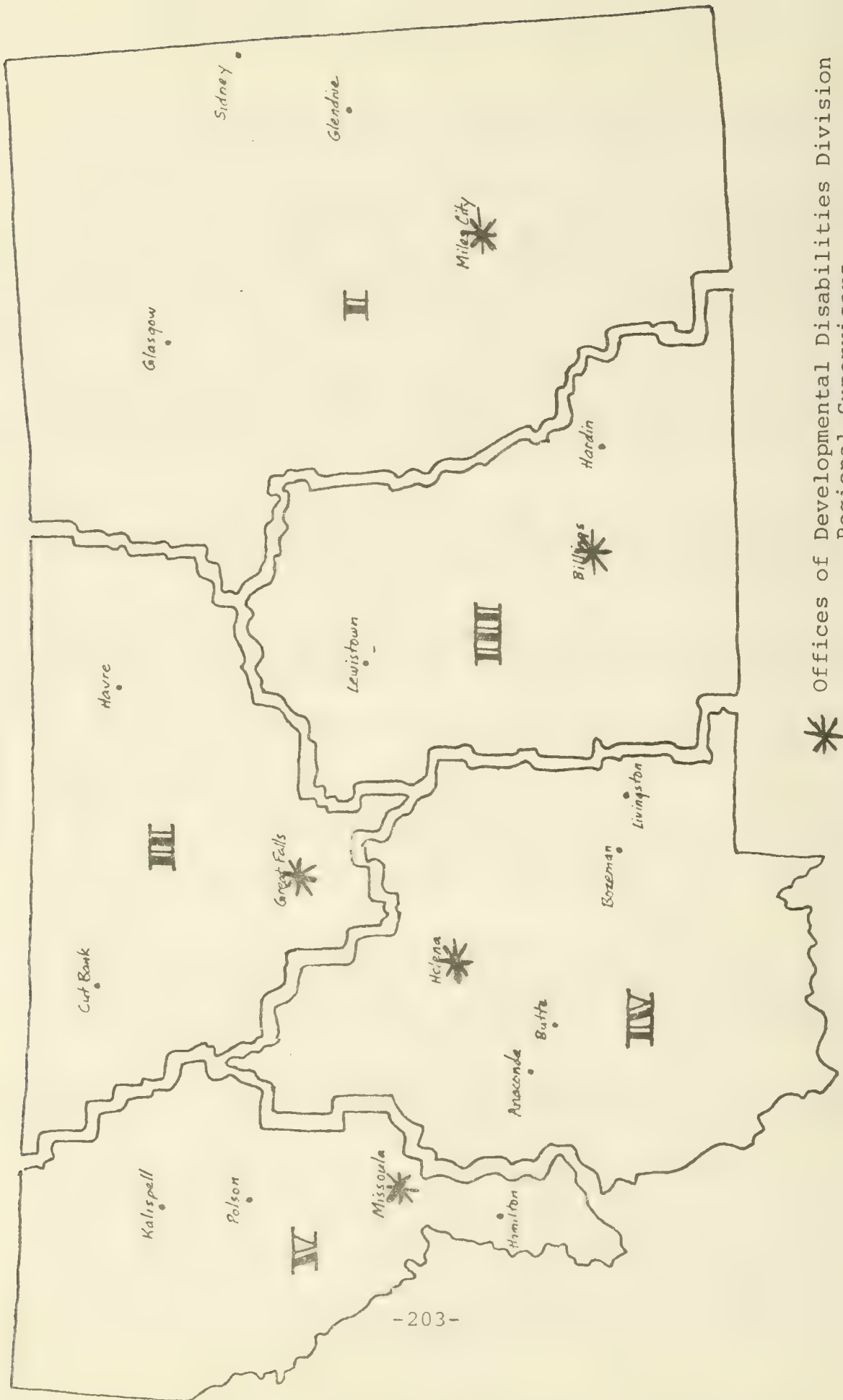
[the following subsections list the counties in each of the five DD regions]

(2) Under guidelines adopted by the department, a citizens' organization approved by the department shall be broadly representative of the region, and at least one-third of its members shall be consumers or representatives of consumers or consumer organizations in the discipline of DD.

(3) A citizens' organization shall be approved under procedures and rules adopted by the department.

(4) A regional council member who is not a full-time employee of the state or of a county is entitled to be reimbursed in an amount to be determined by the department, not to exceed \$25, for each day actually and necessarily engaged in the performance of council duties and for expenses as provided in 2-18-501 through 2-18-503. A council member who is a full-time state or county employee may not be compensated for service as a member of a regional council but shall be reimbursed for expenses as provided for in 2-18-503.

MONTANA



\* Offices of Developmental Disabilities Division  
Regional Supervisors

(5) A regional council shall:

(a) make an annual written review and evaluation of needs and services within the region and provide a copy of the review and evaluation to the planning and advisory council;

(b) advise the department, other state agencies, councils, local governments, and private organizations on programs for services to the DD within the region; and

(c) develop a plan for a system of community-based services for the DD within the region and provide a copy of the plan to the planning and advisory council."

The following section of the Montana Administrative Code 46-2.22 (1) - 52241 (46.8.401) addresses the five regional councils' organizational structures and their roles and responsibilities.

"(1) The director of the department shall recognize a petition by a citizens' organization for a DD regional council under the procedures set forth herein. The petition shall be signed by a majority of the proposed members and shall provide:

- (a) that the proposed council has not more than twenty (20) members;
- (b) the names and addresses of each proposed council member;
- (c) that the citizens' organization is broadly representative of the region and at least one-third (1/3) of the council's members are consumers or representatives of consumers or consumer organizations in the discipline of DD;
- (d) that no proposed members are employees of the department of SRS or employees of a provider service program funded wholly or in part through the DDD;
- (e) that the citizens' organization held at least three (3) public meetings in different areas of the region and that the public was encouraged to attend and participate in the formation of a regional council.
- (f) that the public was given adequate notice of the meetings by means of local news media such as radio, newspapers and television throughout the region;

- (g) that the organization has compiled by-laws for the proposed council; and
  - (h) that a recognized regional council for DD does not exist for that region.
- (2) A citizens' organization shall submit its petition to the director, department of SRS, P.O. Box 4210, Helena, MT 59601. The director shall notify the citizens' organization, in writing, no later than thirty (30) days after receipt of the petition whether the citizens' organization is approved as a regional council for DD.
  - (3) Citizens' organizations approved by the department as regional councils prior to December 1, 1979, shall be treated as if approved in accordance with the provisions of this section.
  - (4) Regional councils shall file with the director of the department no later than October 1 of each year, current copies of council by-laws and council membership lists. The council membership list shall include sufficient information about council members to verify that the council is constituted in accordance with the laws of the state and this chapter provided, however, that any person who is a member of a regional council on January 1, 1980, may complete his or her term. Notice of approval or non-approval of by-laws and membership will be sent by the director no later than November 1. Any regional council not in compliance with the provisions of this chapter will be provided a period of time, as determined by the director, which will be no less than thirty (30) days, to correct such situation.
  - (5) Regional council by-laws. A regional council shall adopt by-laws which shall set forth:
    - (a) a stated purpose;
    - (b) the council duties, consistent with law;
    - (c) that membership on the council, except for vacancies occurring for any reason during a member's term, will be determined by election held at a public meeting which has been advertised in the news media throughout the region for a set number of days, and for which a set number of day's notice has been given; and which persons present are eligible to vote in such elections;



- (d) that no members are employees of SRS or employees of a provider service program funded wholly or in part through the DDD;
- (e) provisions which:
  - (i) identify potential conflict of interest situations for council members;
  - (ii) detail the manner in which such conflicts will be handled, which provisions must, at a minimum, restrict a member from evaluating a service program in which the member has a direct interest or voting on any matter, the outcome of which will directly affect a member's interest; and
  - (iii) provide for the monitoring of such conflict of interest provisions.
- (f) provisions governing terms for members;
- (g) provisions for filling vacancies created on the council during members' regular terms;
- (h) provisions for electing officers for the council, for terms of office for officers, and for the filling of vacancies created during terms of office;
- (i) that a quorum shall be at least a majority of the voting membership of the council, including alternates present to represent absent members;
- (j) that the council will conduct regular meetings at least once during each calendar quarter, that records shall be kept of activities of the council and the means by which the public has access to the records;
- (k) that if a committee is created, the purpose and function of that committee; and
- (l) provisions for amending the by-laws.

(6) Regional councils shall:

- (a) Advise the department, other state agencies, councils, local governments, and private organizations on programs for services to the DD within the region;

- (b) make an annual written review and evaluation of needs within the region, including a list of priorities according to the findings of the review, and provide a copy of the review to the department and the DDPAC by December 1 of each year;
  - (c) develop an annual plan for a system of community-based services for the DD within the region and provide a copy of the plan to the department and the planning and advisory council by March 1 of each year preceding the federal fiscal year to which the plan applies;
  - (d) make an annual written review and evaluation of services presently provided within the region and provide a copy of the evaluation to the department and the planning and advisory council by May 1 of each year;
  - (e) provide two names for regional representatives to the planning and advisory council as requested by the council; and
  - (f) inform the department of changes in officers, members and alternates of the regional council, or of changes in the by-laws.
- (7) The department shall employ a regional supervisor for each region to provide technical and administrative assistance to the regional council in:
- (a) preparing a review and evaluation of needs and services;
  - (b) advising the department on programs for services;
  - (c) developing a plan for the DD within the region, and to provide such additional assistance as may be assigned by the division administrator."

REGIONAL DEVELOPMENTAL DISABILITIES ADVISORY COUNCILS  
ROLES AND RESPONSIBILITIES

The philosophy of the Regional Councils is that DD persons have the basic rights of all citizens. They have the right to life, liberty, the pursuit of happiness, and consequently risk, in the least restrictive setting.

The Regional Councils advocate and plan for services for the DD in each of our five regions and we are committed to a system of community-based services to serve the DD citizens in our state.

Roles:

Regional Councils shall:

- a) make an annual written review and evaluation of needs and services within the regions and provide a copy of the review and evaluation to the state planning and advisory council;
- b) advise the department, other state agencies, councils, local governments, and private organizations on programs for services to the DD within the region; and
- c) develop a plan for a system of community-based services for the DD within the region and provide a copy of the plan to the state planning and advisory council.

Responsibilities:

In addition to fulfilling the purposes for which the Regional Councils were formed, the councils shall:

Solicit, promote and advocate for services for the DD within the region from public or private workshops, day activity training centers, universities, colleges, public schools, pre-school nurseries and other public and private agencies and facilities.

Serve within the region in any capacity requested by federal and state law for the administration of federal and state programs for services to the DD.

Review and approve all grant applications and contract proposals for programs for services to the DD within the region and make recommendations to the State Department of SRS and/or the State Planning Council concerning these grant applications and contract proposals.

Provide to the Office of the Governor of the State of Montana, the names of two individuals selected by the Regional Council, one of which when selected by the Governor, will serve as the Regional Representative to the State Council, at least thirty days in advance of the expiration date of the membership to be appointed.

Inform the State DDPAC and the State DDD of SRS should any facility within the region cease to be operated as a program for the DD if the facility was constructed or funded with monies allocated under the Federal DD Services and Construction Act or other Federal or State monies.

These Councils have been organized for charitable purposes only, and not for profit of any member of other person, or for the benefit of any individuals except the DD.



REGION I COUNCIL  
GOALS & OBJECTIVES

COMPONENT I

GOAL 1: TO PROMOTE AND PROVIDE FOR THE CONTINUATION OF FISCAL YEAR 1980 LEVEL FUNCTIONS WHICH PROMOTE A FULL CONTINUUM OF COMMUNITY-BASED SERVICES OFFERING TRAINING FOR INCREASED INDEPENDENCE AND DIGNITY IN THE LEAST RESTRICTIVE ENVIRONMENT FOR ALL DEVELOPMENTALLY DISABLED INDIVIDUALS IN EASTERN MONTANA.

Objective 1: To maintain and provide current level services as of December 1980, for community-based vocational training services serving 119 adults.

Objective 2: To maintain and provide current level services as of December 1980, for community-based residential services serving 65 adults.

Objective 3: To maintain and provide current level services as of December 1980, for 109 children in family training and support services.

Objective 4: To maintain and provide current level services as of December 1980, for community-based transportation services serving 115 persons.

GOAL 2: TO INCREASE THE SKILLS AND CAPABILITIES OF THE REGION I DEVELOPMENTAL DISABILITIES ADVISORY COUNCIL FOR THE PURPOSE OF ADVISING, MONITORING, AND IMPROVING ALL PROGRAMS FOR THE DEVELOPMENTALLY DISABLED PEOPLE IN EASTERN MONTANA.

Objective 1: Provide on-going monitoring and evaluation of all DD Training Programs.

1.1 Council will maintain an evaluation team composed of council members who have been trained to effectively evaluate all service areas listed in the evaluation tool.

1.2 All services provided to DD individuals will be evaluated on a yearly basis.

Objective 2: Conduct a yearly needs assessment of Region I.

2.1 Develop comprehensive service plan based on needs assessment.

Objective 3: Review and make recommendations of Service Providers contracts on a yearly basis.

Objective 4: To promote communication and coordination for all public and private resources serving developmentally disabled persons within Region I.

4.1 To invite participation of human service providers at Regional Council meetings.

4.2 Recommend and promote that all community human service agencies cooperate in providing a continuum of services to the developmentally disabled of Region I.



Objective 5: To promote increased public awareness of services available to the developmentally disabled.

5.1 Develop a resource guide for all services which are provided to developmentally disabled persons and distribute.

5.2 Arrange for public meetings to be held in conjunction with Region I Council meetings to inform the public of our services.

Objective 6: This plan will be reviewed quarterly and amended when necessary.

6.1 To distribute this plan to all programs serving the developmentally disabled in the Region to obtain their input and comments.

## COMPONENT II

Based on a needs assessment conducted by our council and the DD Regional staff, we have documented our needs in terms of:

(1) Additional ancillary services needed

(2) Expansion of existing services

(3) Development of new services

GOAL 1: TO PROVIDE A QUALITY COMPREHENSIVE SERVICE DELIVERY SYSTEM TO ALL IDENTIFIED DEVELOPMENTALLY DISABLED INDIVIDUALS RESIDING IN REGION I.

Objective 1: To provide appropriate vocational services for 60 unserved community individuals residing in Region I.

1.1 Expand current vocational programs to service an additional 30 developmentally disabled persons.

1.2 Develop a new vocational training program in the Wolf Point, Poplar area to serve 13 developmentally disabled persons.

1.3 Develop a new vocational training program in Glendive to serve 7 developmentally disabled persons.

1.4 Develop a new vocational training program or re-direct a portion of an existing program aimed at appropriately serving 10 elderly developmentally disabled persons who are currently in nursing homes or foster homes.

1.5 Provide for the addition of job-placement specialist staff in the vocational training programs to facilitate client movement into competitive job markets.

Objective 2: To provide appropriate residential services for 48 unserved developmentally disabled community persons residing in Region I.

2.1 Develop 4 new adult group homes to serve 32 developmentally disabled adults.

2.2 Develop one new children's group home to serve 4 developmentally disabled children.

2.3 Develop 2 new Semi-independent programs to serve 8 developmentally disabled adults.

2.4 Expand current Semi-independent programs to serve 4 additional developmentally disabled adults.

2.5 Encourage the development of a network of adequately funded intensive care foster homes for developmentally disabled children.

Objective 3: To provide appropriate transportation services for 60 unserved developmentally disabled community persons residing in Region I.

3.1 Increase transportation capabilities including efficient energy maintenance, vehicle replacement and services to individuals residing in remote rural areas.

Objective 4: To provide appropriate family training and support services for 22 unserved community families residing in Region I.

4.1 Expand the current Family and Children service programs to serve an additional 22 families.

4.2 Develop the capabilities to provide case coordination to all children and their families who are receiving training.

Objective 5: To provide for diagnostic, evaluation and support service through local resource centers for persons of all ages.

5.1 Support the continuance of the Developmental Assessment Service which provides a comprehensive evaluation of persons 0 - 21.

5.2 Develop and support the expansion of DAS to provide evaluations of all developmentally disabled persons regardless of age.

Objective 6: To provide for a region-wide program of prevention of developmental disabilities.

Objective 7: To provide for compliance to accessibility standards for group homes and day programs.

7.1 Insure that each community where services are provided has at least one accessible group home.

7.2 Insure that each community where services are provided has at least one accessible day program.

Objective 8: To provide for up-grading the quality of residential services through competitive direct service staff salaries, appropriate staffing ratios and staff resources for emergency interventions.

GOAL 3: TO PARTICIPATE IN A STATEWIDE PROGRAM OF DEINSTITUTIONALIZATION.

3.1 Encourage a review of Eastmont clients by all Client Service Specialists and insure that Region I is not left with this entire responsibility.

## REGION II COUNCIL

### GOALS & OBJECTIVES

The broad goals, specific objectives and methods to reach the objectives which have been set up to give direction to the council activities for the coming year are as follows:

- A. To strengthen the present service network.
  - 1. To explore Title XIX funding for eligible programs in Region II.
  - 2. To advise providers on the implementation of energy conservation policies in all contracted services.
  - 3. To continue to support the Region II Advocacy Program.
  - 4. To operationalize the role of the Region II DD Council.
  - 5. To work with providers on ways of dealing with fuel cost increases.
  - 6. To support ACMR DD Accreditation for Region II DD programs.
  - 7. To implement training of DD Case Managers by RCT's.
  - 8. To recommend a preventive maintenance plan for each program in Region II.
  - 9. Each provider contract in Region II will have a goal to increase community knowledge of DD and the role of each provider in the community.
  - 10. Each provider contract in Region II will have a goal to increase the integration of DD individuals into the community.
  - 11. A review of current day services in Great Falls will be performed.
- B. To serve unserved DD persons within Region II that are on waiting lists.
  - 1. To develop a plan for dealing with the projected special education graduates in the region over the next biennium.
  - 2. Begin exploring Day Services for Deaf/Blind children residing in Group Homes in Great Falls.

- C. To serve DD persons in Region II that are presently in a DD program but in need of placement in a less restrictive alternative.
  - 1. To provide services to individuals on waiting lists who are receiving other DD services.
  - 2. To provide services to individuals in group homes who have been identified as ready to move to semi-independent living.
  - 3. To follow closely the number of placements of DD clients on jobs.
  - 4. To begin looking at developing semi-independent programs in communities that need the service.
- D. To continue deinstitutionalization of residents from Region II that reside at Boulder River School & Hospital.
  - 1. In those areas where an appropriate community placement is not available, placements from BRS&H will continue to be made.
- E. To support the development of services for DD people who are in need of generic services not provided through the DDD.
  - 1. To continue to support the development of an evaluation and diagnosis component for Region II.
  - 2. To continue efforts to obtain speech therapy, physical therapy, occupational therapy and mental health services for all DD clients in Region II in need of such services.



## REGION IV COUNCIL

### PROGRAM PLAN

The Region IV Council supports in this order:

1. The maintenance of quality services to current clients.
2. The expansion of service alternatives to present clients and the expansion of present services to new clients, based on the availability and the continuation of funding.
3. The development of new services based on demonstrated need and on the availability of both startup and continuing funding.

The Council will encourage the development of priority services as money becomes available and will request the DDD to call for proposals to meet identified needs.

Project proposals should be designed:

- a. To meet service needs of present clients;
- b. To serve institution clients in the community;
- c. To maximize the use of other funding sources;
- d. To demonstrate community support;
- e. To offer service alternatives to meet individual needs;
- f. To serve unserved or inappropriately served clients; and
- g. To maximize the use of generic services.

The Council will review and make its recommendation with reference to the following six questions:

1. How does the project fit in with the Regional Plan/Priorities?
2. How many institution clients can be served?
3. How many community clients can be served?
4. What is the cost compared with similar projects?
5. What are the side benefits or deficits?
6. What is the plan for ongoing maintenance of the service?

The Council recognizes the limitations on program development within the next fiscal year but intends to have an extensive plan with specific objectives prior to the next meeting of the legislature.



## REGION V COUNCIL

### GOALS & OBJECTIVES

Following are some of the areas which the Region V Council will be looking at in depth:

1. To become knowledgeable of existing programs and services available to the DD in the region.
2. To establish a means of reviewing existing or proposed DD funded programs and services to determine quality and need.
3. To determine what additional programs are needed and to foster their development in accordance with the concept of regional planning.
4. To interact with programs and services not funded with DD monies and assist or advise or advocate improved services to the DD.
5. To improve public relations and the information and referral process in the region.



Section 3

REHABILITATIVE SERVICES DIVISION





## REHABILITATIVE SERVICES DIVISION

### A. Rehabilitative Services Bureau:

This is the principal state program to provide needed services to vocationally handicapped people, of employable age, to restore them to gainful employment. Program emphasis is on serving first the severely disabled. Required Vocational Rehabilitation services will be furnished an individual if found by diagnostic study to require such services.

Eligibility for Vocational Rehabilitation will be determined upon the basis of these established criteria: (1) The presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment; and (2) a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

Vocational Rehabilitation Services means any goods and services necessary to render a handicapped individual fit to engage in a gainful occupation. These include: evaluation of rehabilitation potential; counseling, guidance, and referral; physical and mental restoration services; vocational and other training services; maintenance; transportation; services to members of a handicapped individual's family necessary to the adjustment or rehabilitation of the handicapped individual; interpreter services for the deaf; reader services, rehabilitation teaching services, and orientation and mobility services for the blind; telecommunications, sensory, and other technological aids and devices; recruitment and training services to provide new employment opportunities in rehabilitation, health, welfare, public safety, law enforcement, and other appropriate public services employment; placement in suitable employment; post-employment services necessary to assist handicapped individuals to maintain suitable employment; occupational licenses, tools, equipment such as initial stocks (including livestock) and supplies; and other goods and services which can reasonably be expected to benefit a handicapped individual in terms of his employability.

Administration of a non-VR Program for Life Saving Treatment for Chronic Renal Disease only with State dollars.

FUNDING: 80% Federal - 20% State

Vocational Rehabilitation Amendments of Social Security Act  
- P.L. 93-112

Title I Section 110

Part 1361, Chapter XIII of Title 45 of Code of Federal Regulations.

### B. Special Projects Bureau:

This Bureau has been specifically assigned to insure the effective establishment and utilization of rehabilitation facilities, especially

the work and evaluation oriented ones; to implement special rehabilitation projects or programs in Montana for the most beneficial use of rehabilitation clients and others; and to evaluate the effectiveness of the Vocational Rehabilitation program in Montana.

Parts 1361 and 1362, Chapter XIII of Title 45 of Code of Federal Regulations.

C. Disability Determination Bureau:

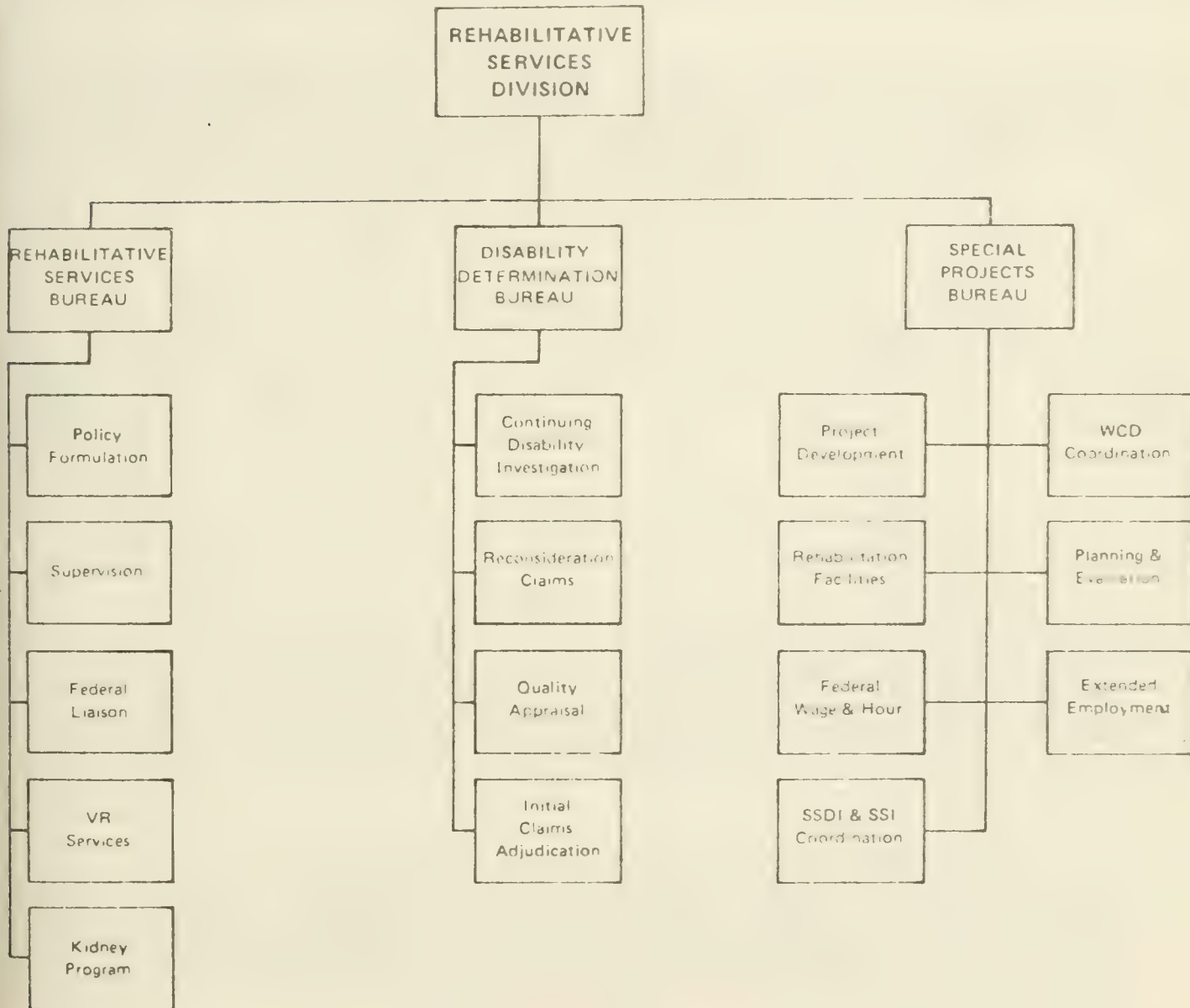
The Disability Determination Bureau is responsible for allowance and denial decisions on applications for Social Security Disability Benefits on Montana residents. The primary purpose of the Disability Insurance Program is to provide partial replacement of earnings lost because an individual is precluded from engaging in substantial gainful activity due to a physical or mental impairment.

Applications for Supplemental Security Income Disability Benefits are also adjudicated by the Disability Determination Bureau. This is a new Federal Assistance Program which provided a national income floor for the aged, blind and disabled who have met an income and resources requirement.

This program is administered by the Social Security Administration.

FUNDING: All funding for the Disability Determination Bureau comes from the Social Security Administration, Bureau of Disability Insurance.

ORGANIZATIONAL STRUCTURE OF  
THE REHABILITATIVE SERVICES DIVISION



rehabilitation facilities, the monitoring of special programs and funding sources, and the planning and evaluation for the Rehabilitative Services Division.

Basic vocational rehabilitation services are available to any Montanan of employable age who has a physical or mental disability which constitutes or results in a substantial handicap to employment and for whom there is a reasonable expectation that vocational rehabilitation services may be of benefit in terms of employability.

The following Table summarizes the Rehabilitative Services Division budgets for 1977, 1978 and 1979 and its proposed 1980 budget.

REHABILITATIVE SERVICES DIVISION  
BUDGET BY YEAR AND SOURCE OF FUNDING

<u>SOURCE</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>
State	\$ 960,000	\$ 953,577	\$ 963,878	\$ 878,260
Federal	3,040,000	2,958,999	3,133,799	200,000 3,315,856
Total	\$4,000,000	\$3,912,576	\$4,097,677	\$4,394,116

The Rehabilitative Services Division serves a total of approximately 10,000 clients per year. At any given time, about 6,000 Montanans are receiving some vocational services from the Division. The Division attempts to include developmentally disabled individuals as 50% of its caseload. The following Rehabilitative Services Division services are particularly relevant to developmentally disabled clients.

Evaluation and Diagnosis

This service is designed to determine medical eligibility for services and develop the medical, psychological, social and vocational information necessary to develop an appropriate plan for services. Evaluation and diagnosis is available to anyone seeking the service without regard to the individual's available financial resources.

Training And Training Materials

Rehabilitative Services Division staff and contractors provide training in vocational, pre-vocational, personal adjustment, and other areas deemed appropriate for successful vocational adjustment. Training is provided without regard to income level while training materials and books are provided at no charge only to low income clients.



## Physical Restoration Services

These are a wide range of medical and medically-related services such as physical, speech, and occupational therapies, which are furnished if such services are likely to reduce a client's handicapping condition within a reasonable length of time. Eligibility for physical restoration services is income related.

## Transportation

Transportation is provided to those Rehabilitative Services Division clients who meet low-income requirements and who need transportation to and from vocational rehabilitation services.

## Placement

Placement services are provided, without regard to income level, to all clients. For a minimum of 60 days following vocational placement, Rehabilitative Services Division staff provide follow-along services to assure the appropriateness and continued success of the client's placement.

## Post-Employment Services

Extended follow-along and counseling activities after placement and case closure are provided for some clients. These services are provided without regard to income and are intended to monitor former clients who are in gainful employment.

Rehabilitative Services Division services are provided by a staff of 35 Rehabilitation Counselors and 10 Rehabilitation Aides located in 13 offices and 5 sub-offices throughout the State. Each of the five regions has a district office. A District Supervisor in each of these offices oversees the activities of the personnel in the region. The map on the following page shows the locations of the Division offices and sub-offices.

The Division has a need to purchase Vocational Evaluation, Work Adjustment Training and VR-Extended Employment from only eight rehabilitation facilities. All eight facilities are work oriented. One also possesses a strong medical orientation. The locations of the facilities are shown in the map on the following page.

During 1979, the last year for which complete data exist, the Rehabilitative Services Division served a total of 4266 developmentally disabled clients. The following Table is a breakdown on these clients by region and disability. The total 1979 caseload was 8559. The Division, therefore, had a DD caseload equal to 49% of all cases.

There are two factors which affect the availability of vocational rehabilitation services to developmentally disabled individuals: 1) Because the Rehabilitative Services Division requires that clients be able to benefit from its services in terms of employability, very severely developmentally disabled individuals are likely to be found

## REHABILITATIVE SERVICES DIVISION OFFICES



## REHABILITATION FACILITIES



APPROXIMATE NUMBER OF DEVELOPMENTALLY DISABLED CLIENTS  
SERVED BY REHABILITATIVE SERVICES DIVISION IN 1979 BY  
REGION

	DD CLIENTS SERVED	DD CLIENTS PLACED IN GAINFUL EMPLOYMENT
	<u>TOTAL</u>	<u>TOTAL</u>
REGION I	597	69
REGION II	768	88
REGION III	939	108
REGION IV	981	113
REGION V	981	112
<hr/>		
MONTANA	4266	490

ineligible for service. It is likely in fact, that some Division clients with one or more handicapping conditions included among the developmental disabilities would not be considered "substantially handicapped" as the term is defined in Section II of this Plan. As can be seen by the map, the distribution of Rehabilitation Counselors and training facilities in the State makes difficult the identification of potential clients and the delivery of services in many areas.

The Rehabilitative Services Division requires that each client have an Individualized Written Rehabilitation Program (IWRP) which is reviewed and, if necessary, revised yearly. This service plan is an agreement developed by the Rehabilitation Counselor, the client, and when appropriate, the client's advocate. It specifies the responsibilities which the Counselor, the Division, and the client have in order to successfully rehabilitate the client.

#### Quality of Services

All rehabilitation facilities under contract with the Rehabilitative Services Division maintain the standards specified by and are accredited by the Commission of Accreditation of Rehabilitation Facilities.

The quality of services provided by Rehabilitation Counselors and Aides is monitored by District Supervisors. Use of Case Review and Peer Review enables a review of quality of services.



The Division has, for the past several years, followed up on clients whose cases have been closed for one or two years. Information about the kind of work (if any) the former client is doing and the former client's own evaluation of Division services is gathered. In general, these studies have yielded results indicating that the Rehabilitative Services Division provides services of high quality. The following Table shows the responses of former clients who, one or two years after case closure, were asked whether they would recommend vocational rehabilitation to a disabled friend.

RESPONSES OF FORMER REHABILITATIVE SERVICES  
DIVISION CLIENTS ASKED WHETHER THEY WOULD  
RECOMMEND VOCATIONAL REHABILITATION.

<u>Status of Client at Case Closure</u>	<u>Severely Disabled Clients</u>		<u>Non-Severely Disabled Clients</u>	
	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
No services had been provided	8	0	17	1
Client gainfully em- ployed	22	0	32	0
Services provided, but not gainfully employed	22	0	13	3
Accepted for service, but no service plan developed	11	1	14	2
TOTALS	63	1	76	6

The data in this table indicate that the great majority of former clients have favorable opinions of vocational rehabilitation regardless of the success of the services they received.

During 1982 the Rehabilitative Services Division plans to continue its policy of including developmentally disabled clients as 50% of its caseload. The following goals and objectives set by the Division for 1980 and the 1982-83 biennium are relevant to developmentally disabled individuals.

GOAL A To insure the provision of quality vocational rehabilitation services to all applicants with continuing emphasis on increasing services to the severely disabled population.

## OBJECTIVES

1. To continue to serve those requiring VR service from the approximately 40,000 handicapped in Montana between ages 16 and 64 (1970 Census). VR will serve 10,000 people in 1980, and 11,000 people in 1981.
2. To increase the number of persons rehabilitated into gainful employment from 1,300 in 1980 and 1450 in 1982.
3. To increase the percentage of severely disabled served from 49% in 1980 and to 50% in 1982.
4. To decrease the number of training cases in colleges from 35% to 30% in 1980-81, as the VR program is a second resource for higher education.
5. To increase the number of clients in On The Job Training (OJT) to at least 20% of total training cases from the present 16%.
6. To decrease the average caseload size from 300 per counselor to 150 per counselor in 1980-81 in order to more effectively deal with the increasing number of severely disabled cases.
7. To evaluate segments of the program in order to build strengths and to correct or eliminate non-productive areas. Evaluation to center on:
  - a. the effectiveness of service in Rehab facilities;
  - b. followup on closed cases;
  - c. the placement efforts of VR staff;
  - d. a comparison of client's weekly earnings at closure with weekly earnings after one year;
  - e. the relationship of training to client's occupation at followup;
  - f. a check on former clients' continued employment;
  - g. a followup on those cases closed as too disabled - to see if service is now feasible.
8. To continue providing in-service training to Rehabilitation Counselors that emphasizes the availability of benefits from other programs in order to increase the amount of first resource use from other programs, thereby reducing unwarranted use of vocational rehabilitation funds.
9. To continue providing in-service training of staff in order to eliminate gaps in service programs, thereby providing prompt, complete and overall comprehensive services to clients.



GOAL B

To provide Extended Employment services in the seven rehabilitation facilities in order to prevent, or provide an alternative to, institutionalization, dependence, and idleness.

OBJECTIVE 1 To increase statewide utilization of available sheltered employment slots in 1982-83.

Proposed Program Modifications for Vocational Rehabilitation Program

1. The VR average case cost has increased at 13 each year since 1976. Therefore, to maintain the program at the same level, additional funds are required. An increase in funding by 8% each year will require, in addition to current funding levels:

FY 1982 - \$4,000,000 total funds, including \$80,000 state

FY 1983 - \$2,000,000 total funds, including \$40,000 state

2. To assist 300 applicants with Independent Living Rehabilitation Services.
3. To provide funding for establishment of Independent Living Rehabilitation Centers.
4. To add staff (2 F.T.E.) for job placement of clients.
5. To add 25 slots for clients of the extended employment program.
6. To add staff (3 F.T.E.) for better service to the non-VR Kidney program applicants.

Objectives for the Special Projects Bureau:

1. To expand usage and resource power of the existing comprehensive rehabilitation work facilities, and work activity centers.
2. To promote usage of such rehabilitation facilities by other than the state rehabilitation agency.
3. To assure appropriate professional and legal certification of rehabilitation facilities.
4. To continue the development of a comprehensive rehabilitation center in a major population area.
5. To regulate establishment and growth of work-study programs.
6. To increase the number of Industrial Accident applicants and beneficiaries, Social Security beneficiaries, and Supplemental Security recipients served and successfully rehabilitated.

7. To direct special projects monies to the appropriate recipients.
8. To coordinate planning and implement evaluation for the vocational rehabilitation program.
9. To subsidize extended employment services in workshops and work activity centers.
10. To provide appropriate training to all levels of the VR staff.



TABLE 3.A

**SERVICES PROVIDED**

Agency: SRS  
Program: RSD

**CASE MANAGEMENT SERVICES**

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-up After	Initiation of Eval. Provided
1. Evaluation & Diagnosis	X	X	X		X		
2. Transportation				X			
3. Placement	X					X	
4. Post Employment Services		X			X	X	
5. Sheltered Workshops	X		X				

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Table 3. A

**MEDICAL SERVICES - REHABILITATIVE SERVICES**

Service	Adult Diagnostic and Evaluation	Surgery and Treatment	Appliances	Hospitalization	Other Services
1. Medical Services for Individuals	X	X			
2. Prosthetic	X		X		
3. Orthopedic	X		X		
4. Hospital & Convalescent				X	X
Physical Medicine Rehab Center					X
Other Restoration	X	X			X

TABLE 3.A

Service	NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE					Work/Day Activities
	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	
1. Training & Training Materials	X		X		X	
2. Transportation		X	X			
3. Sheltered Workshops						X



## NUMBERS OF PERSONS SERVED

Table 3.B

## CASE MANAGEMENT - REHABILITATIVE SERVICES

REGION	ASSISTING WITH ACCESS			CAPACITY FOR MORE			FOLLOW ALONG			CAPACITY FOR MORE			COORDINATION OF SERVICES			CAPACITY FOR MORE			OTHER SERVICES			CAPACITY FOR MORE		
	TOTAL	DD		YES	NO	CONSTRAINT	TOTAL	DD		YES	NO	CONSTRAINT	TOTAL	DD		YES	NO	CONSTRAINT	TOTAL	DD		YES	NO	CONSTRAINT
I	368	184					126	63					368	184					1322	661				
II	480	240					164	82					480	240					1677	838				
III	516	258					176	88					516	258					1784	892				
IV	610	305					208	104					610	305					2057	1028				
V	597	298					204	102					597	298					2021	1010				

## CONSTRAINTS TO SERVICES

The following constraints apply to all aspects of services unless otherwise specified.

1. Funding keeps caseload down - more funding would loosen priorities allowing more services to more severely disabled.
2. Lack of public awareness programs.
3. Counselors' caseloads are to large creating problems with job placement and followup.

Table 3.2.

## MEDICAL SERVICES - REHABILITATIVE SERVICES

REGION	DIAGNOSTIC AND EVALUATION		CAPACITY FOR MORE			SURGERY AND TREATMENT			CAPACITY FOR MORE			APPLIANCES,			CAPACITY FOR MORE			HOSPITAL AND CONVEY- CENT			CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT			
I	184	92				29	18				35	17				8	4						
II	240	120				38	19				45	22				11	5						
III	516	258				40	20				49	24				12	6						
IV	610	350				48	24				58	29				14	7						
V	576	288				47	23				56	28				14	7						

Table 5. B

## MEDICAL SERVICES - REHABILITATIVE SERVICES (Cont)

[illegible]

Table 3. B NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES - REHABILITATIVE SERVICES

REGION	Asst. w/ DAILY LIVING		CAPACITY FOR MORE			WORK ACTIVITY		CAPACITY FOR MORE			OTHER		CAPACITY FOR MORE			CAPACITY FOR MORE	
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD
I	240	120				48	24				1408	704					
II	314	157				63	31				1818	909					
III	337	168				68	34				1947	973					
IV	398	199				80	40				2287	1143					
V	390	195				78	39				2240	1120					



Section 3

SCHOOL FOR THE DEAF & BLIND





## MONTANA SCHOOL FOR THE DEAF/BLIND

The Montana State School for the Deaf and the Blind is located on an 18 acre campus in the City of Great Falls. The School is administered by a superintendent and is governed by the State Board of Public Education. Laws establishing the School and pertaining to its operation are to be found in Title 20, Chapter 8, Part 1, MCA 1979.

Under the provision of that law, the State Board of Public Education directs that the following procedures shall govern the admission of students at the Montana State School for the Deaf and the Blind:

1. The parent or legal guardian must complete an application for admission.
2. A medical examination form must be filed from the family doctor.
3. Appropriate data and/or assessment of hearing loss or impairment of vision must accompany the application.
4. The parent or guardian, with the child, must visit the School.
5. Within practical limitation of time, but not exceeding six months, a Child Study Team shall be called on each child admitted or considered for admission. The composition of the Child Study Team shall follow the rules and regulations set forth by the Office of the Superintendent of Public Instruction.
6. A Child Study Team shall be called yearly for reassessment of the child's placement at the School.

The School operates on a 9 month schedule running from approximately the first week in September to the first week in June. The residence facilities are open for these months except for all scheduled school holidays when all children are required to go home. The dormitory is maintained and staffed with competent people for those children who live outside the City of Great Falls.

Any child who is a resident of Montana and is educationally disadvantaged because of a hearing loss or sight loss is eligible for admission to the School based upon recommendations of the Child Study Team. Minimum age limitations have been removed by legislative action. Maximum age of attendance is 21 years.

## Educational Departments

### Department for the Hearing Impaired

A comprehensive program of education and training encompasses preschool, kindergarten, elementary, and junior-senior high school. The general course of study followed in Montana schools is adhered to as closely as possible except that the hearing impaired student requires greater emphasis in language, reading and speech.

A specially trained staff of teachers is supported by specialized professionals such as speech therapists, a librarian, an audiologist, a school psychologist, a physical therapist, and a registered nurse.

Instructional methods and materials are consistent with up-to-date guidelines within this specialized area of education. Child Study Team meetings held in accordance with Public Law 94-142 devise the educational approach best suited to the needs of the individual child.

A program of home training for preschool students and their parents (Parent Infant Program) is provided throughout the state. Parent Advisors, in cooperation with the child's parents, implement the program through home visitation and evaluation of the child's progress in accordance with program objectives. Resource staff from the School travel throughout the state visiting the homes of hearing impaired children, assisting parents with information and guidance for their child.

In addition to the academic program, junior-senior high students are integrated into the Great Falls Public School system primarily for vocational and physical education classes. Interpreter/tutors are provided as support personnel for the students. In cooperation with the Division of Vocational Rehabilitation, a program of on-the-job training and job sampling experiences is arranged for selected students.

### Department for the Visually Impaired

Within the limitations of individual abilities and local educational facilities, it is not only possible but most advantageous for the child to re-enter regular public school classes. Our program is aimed at this objective.

An elementary academic program is provided and staffed by qualified teachers. A regular high school curriculum is not offered at the School. By ninth grade, students are either transferred to their hometown school or are entered as students in the Great Falls public school system.

To support this program of integrating visually impaired students in the regular classroom, a staff of resource personnel works out of the School to lend support and expertise to the local school administration and the classroom teacher. Additionally, specialized tools and materials as required are provided the students.

### Department for Deaf/Blind & Blind/Multi-Handicapped

The program for deaf/blind children has two locations--one at Boulder River School and Hospital, and one at the Montana School for the Deaf and Blind.

The Deaf/Blind & Blind/Multi-Handicapped program is conducted on a strictly individual behavioral objective basis aimed at developing skills in five areas:

1. Self-help skills
2. Communication
3. Motor Skills
4. Social Skills
5. Cognitive development

The curriculum and procedures used follow recommendations and guidelines provided by the Mountain Plains Regional Center for Services to Deaf/Blind Children.

There are no fees or charges for education or room and board. These costs are fully covered by School funds.

Parents or guardian must be responsible for the following costs:

1. Examination by physician (mandatory for entrance), and an annual summer physical thereafter.
2. Transportation to and from School for all required school holidays. (Local school districts may be contacted for state and local reimbursement.)
3. Personal needs of the child, such as clothing, toiletries, spending money, etc.
4. Medical treatment, examinations, hospitalization, therapy, medicines, etc. (Routine examinations for minor ailments are provided by medical staff at the School.)

Transfer students are accepted in any department of the School upon recommendation of the transferring school administration and supporting medical evidence.

### Goals and Objectives

#### A. Department for the Hearing Impaired

1. To provide a comprehensive program of education and training including preschool, kindergarten, elementary, and junior-senior high schools.
2. To provide a home training program for preschool students and parents through home visitation and evaluation of the child's progress, as well as assisting parents with information and guidance for their child.
3. To provide support personnel in order that students may be integrated into the public school system.
4. In cooperation with Vocational Rehabilitation, to provide on-the-job training and job sampling experiences for selected students.

#### B. Department for the Visually Impaired

1. To provide an opportunity for training and objective stimulation for the preschool and kindergarten visually-impaired child.
2. To provide a solid elementary curriculum.
3. To teach each individual child the special learning skills he will need throughout his life (specifically, Braille skills and study skills).
4. To prepare the individual child to cope with his environment and learn independence in movement and travel.
5. To prepare the child to re-enter a regular public school class.



# SERVICES PROVIDED

TABLE 3.A

Agency: State Board of Education  
Program: MSD&B

## ALTERNATIVE COMMUNITY LIVING SERVICES

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
Deaf	X	X		X		X	X	X
Blind	X	X		X		X	X	X
Deaf/Blind & Multi-handicapped	X	X		X		X	X	X

TABLE 3.A

Agency: St. Board of Education  
Program: MSD&B

## CASE MANAGEMENT SERVICES

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-up Along	Evaluation of Svcs. Provided
Deaf	X	X	X	X	X	X	X
Blind	X	X	X	X	X	X	X
Deaf/Blind and Multi-handicapped	X	X	X	X	X	X	X

TABLE 3.A

Agency: State Board of Education  
Program: MSD&B

## CHILD DEVELOPMENT SERVICES

Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
Deaf	X	X		X	X	X
Blind	X	X				X
Deaf/Blind & Multi-handicapped	X					X

TABLE 3.A

Agency: St. Board of Ed.  
Program: MSD&B

## NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/Day Activities
Deaf	X			X		
Blind	X			X	X	
Deaf/Blind & Multi-handicapped	X			X	X	X

Agency: State Board of Education  
Program: MSD&B

Table 3. B

[illegible]

Table 3. B

[illegible]



Section 3

SOCIAL SERVICES BUREAU

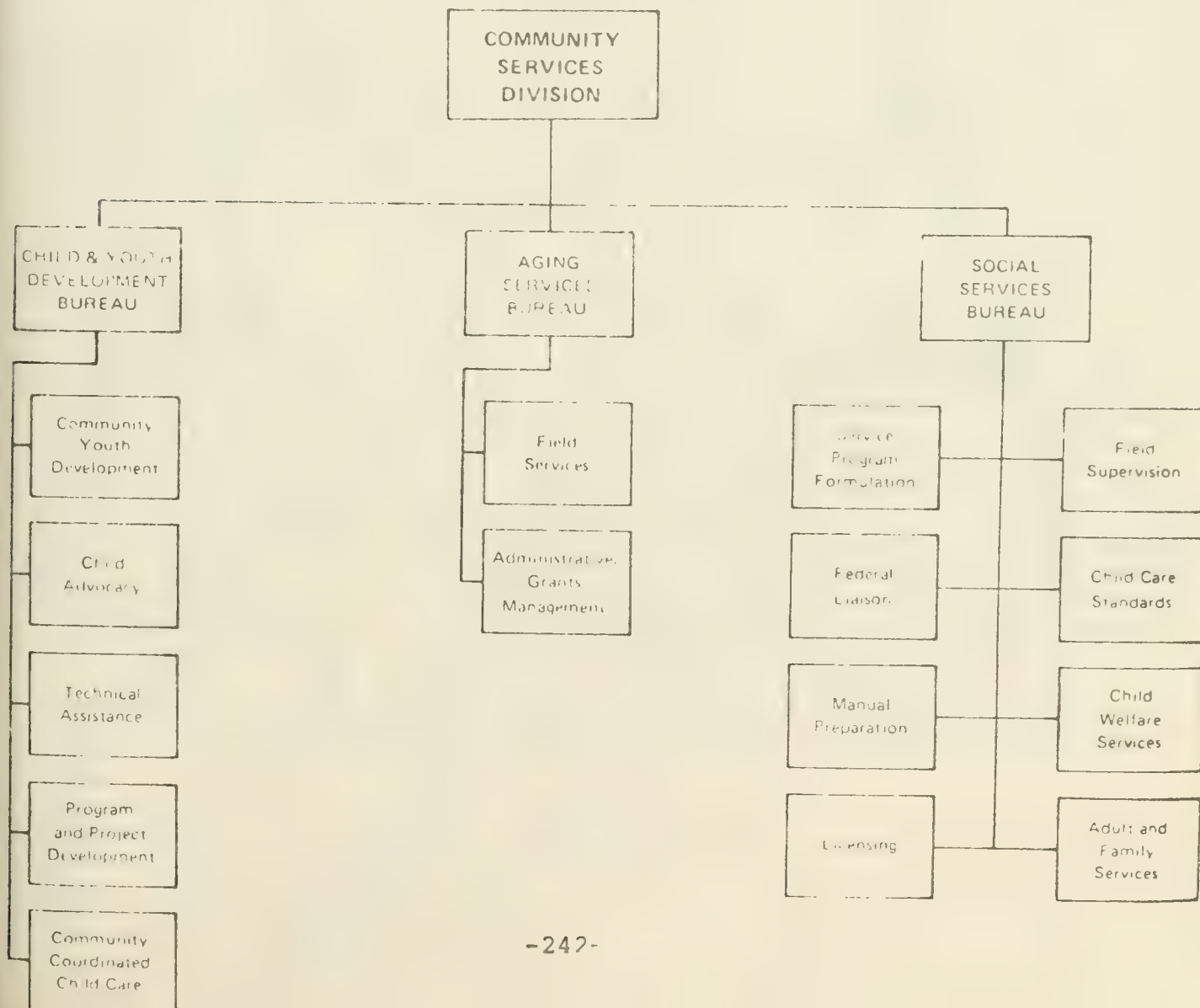




## SOCIAL SERVICES BUREAU

The Social Services Bureau (SSB) is an agency within the Community Services Division of the Department of Social & Rehabilitation Services (SRS). This Bureau supervises the provision of comprehensive social services by county caseworkers. SSB services are primarily aimed at strengthening families, maintaining individuals in the least restrictive environment possible, and enhancing self-sufficiency. The SSB develops policies and supervises all Title XX social service programs that are administered by the county welfare offices for individuals who receive assistance under Titles IV-A, IV-B, XIX, and XVI. Local coordination between the payment (supervised by the Economic Assistance Division) and the social services functions of assistance programs is maintained by staff meetings in county offices. Program and policy coordination is maintained at the State level through inter-division meetings within the Department of SRS.

### ORGANIZATION OF THE COMMUNITY SERVICES DIVISION



Examples of interagency coordination within the Department which directly affect DD individuals are 1) the Social Services Bureau must license community homes funded by the DDD before Supplemental Security Income (SSI) payments can be made; 2) the Social Services Bureau provides case management for DDD clients.

All social services programs are available to DD individuals. Some services, however, are provided contingent upon meeting low income requirements. Certain services are, therefore, available only to those in one or more of the following groups: 1) eligible for Aid to Families with Dependent Children (AFDC); 2) income level less than 80% of the median family income; 3) eligible for Medicaid; 4) receiving SSI; and 5) income level at or near the level established for welfare payments.

### Geographical Regions Served

Montana's 56 counties are divided into five separate geographic regions for the purpose of social service planning. The map on the following page outlines the boundaries of the five regions. The boundaries of the SRS regions are the same planning boundaries as the human service planning areas used by the Department of Health and Environmental Sciences and the Department of Institutions.

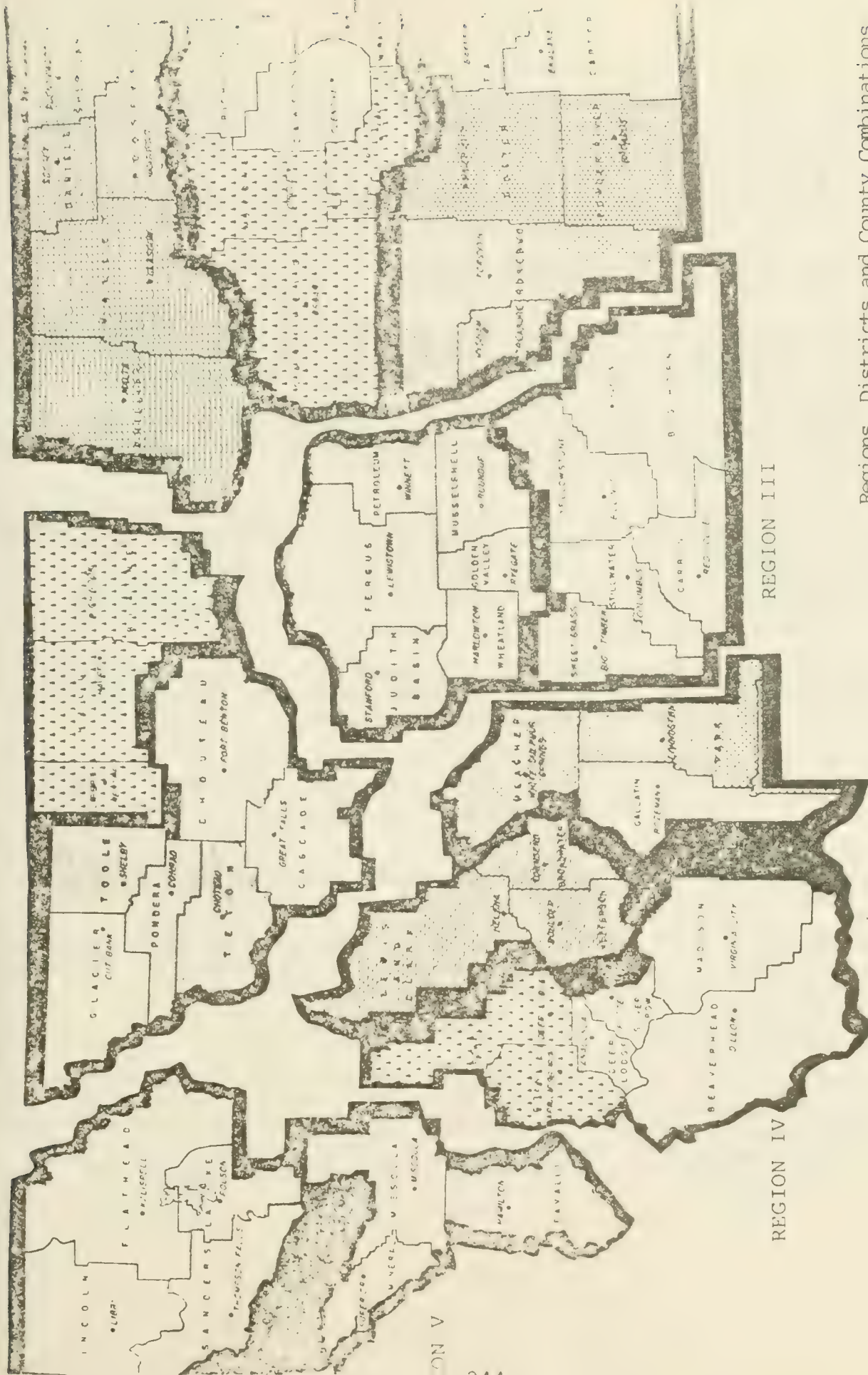
As federal requirement stipulates, any Title XX service provided in a geographic region is available to all eligible individuals who reside in the region. In addition, there is at least one service that is directed toward each of the five Title XX goals available in each of the five geographic regions, and there are at least three services available to SSI recipients in each of the five regions.

### Title XX

Title XX is an amendment to the Social Security Act which was signed into law on January 4, 1975. Title XX is a formula grant to the states for the provision of social service programs. Montana received \$10,173,000 in Title XX funds for social service programs for the 1979 federal fiscal year. The final federal appropriation for the 1980 federal fiscal year, beginning October 1, 1980, is expected to be approximately the same amount. With a few exceptions which are outlined below, the Title XX legislation permits the states to determine the kind of social service programs that are needed without obtaining approval from the federal government. Prior to the implementation of this legislation, the states could fund only certain kinds of programs for welfare recipients who were specifically delineated in the law. In contrast, the Title XX legislation provides the states with more flexibility for planning their own programs.

Funds for Title XX come from a general congressional appropriation; they do not come from Social Security taxes.

## REGION II



## Regions, Districts and County Combinations for Welfare Administration

Unshaded Counties Are Separately Administered



## Title XX Goals and Basic Requirements

The Title XX legislation requires that social service programs which are provided with Title XX funds be directed toward five general goals. These goals are:

1. Achieving or maintaining economic self-support to prevent, reduce or eliminate dependency.
2. Achieving or maintaining self-sufficiency including reduction or prevention of dependency.
3. Preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interests; or preserving, rehabilitating or reuniting families.
4. Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.
5. Securing referral or admission to institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

As required by the law, all Title XX programs in Montana are directed toward one or more of the above goals.

Although Title XX allows the state much more flexibility in deciding how social service funds should be spent than did the previous legislation, the following requirements must be met:

1. At least three services must be provided for SSI recipients in each planning region of the state, and one service directed at each of the five goals must be available in each region of the state.
2. Family planning services and foster care services must be available to all AFDC recipients.
3. 50 percent of the total Title XX funds must be expended for services to categorically related individuals, that is, AFDC, SSI, and Medicaid recipients.

## Ineligible Expenditures

Expenditures which are not eligible for Title XX reimbursement include: construction and capital improvement costs, educational services which are available through the public schools, expenditures which could be made under Medicaid, and most hospital, nursing home and foster care costs. Cash payments to clients are also prohibited.



## Title XX Eligibility

Who is eligible for services provided with title XX funds?

- A. All protective services and information and referral services are provided to anyone regardless of income.
- B. Child care services to children of migrant workers are available as protective services.
- C. Some persons or families are automatically eligible for program services if they are either recipients of AFDC, SSI, or Medicaid. An AFDC recipient is a person whose needs are met in whole or in part by a cash money payment under Title IV-A of the Social Security Act. An SSI recipient is an aged, blind, or disabled person who receives a monthly cash payment made under Title XVI of the Social Security Act.
- D. Some programs are available to any person or family whose income falls within 80% of the state's median family income, as adjusted for family size. The income level, for the 80% median family income requirement, as adjusted for family size is given below:

### Fiscal Year 1980 - Gross Income

Family Size	Monthly	Yearly
1	\$ 568	\$ 6,818
2	743	8,915
3	918	11,013
4	1,093	13,111
5	1,267	15,209
6	1,442	17,307
7	1,475	17,700
8	1,508	18,093
9	1,541	18,487
10	1,573	18,880

## Who determines eligibility?

In some cases eligibility for services is determined by the county welfare office and in other cases eligibility determination is done by the private provider. The following table provides more specific information:

<u>SRS Division or Bureau Responsible for Administering Title XX Programs</u>	<u>Eligibility Determination for Programs</u>
Developmental Disabilities Division	County Welfare offices*
Child and Youth Development Bureau	Private Providers
Social Services Bureau	County Welfare Offices**

\*Except for state-funded programs with no income eligibility. Provider determines eligibility based on the individual being determined developmentally disabled or at risk of developmental delay and being between the ages of 0 through 5.

\*\* Except for legal services and family planning services for which provider determines eligibility.

## Description of Services

### Adoption

#### Program Definition

Adoption services include provision of social services as a protective service to enable appropriate children to be placed in adoptive homes and to provide for the evaluation of non-agency adoptive placements as required by law. Services of this program include initial evaluation, direct evaluation, post and pre-counseling, placement of child, follow up services, follow up evaluation, and recruitment of and/or approval of adoptive homes.

### Objective of Program:

To provide services for adoptive placement of 120 children and to investigate potential adoptive placement of 780 children in order to prevent or remedy neglect, abuse or exploitation of children.

### Day Care for Children

#### Program Definition:

This program provides organized services for the direct supplemental care of children away from the child's home for a portion of a 24-hour day. Monitoring, pre-placement visits and periodic evaluations are provided as they relate to the specific child to meet her/his needs. When food is included, it provide less than three meals per day and does not meet the full nutritional needs of those served.

#### Objective of Program:

To provide supplemental care for 525 children in danger of neglect, exploitation, or abuse including day care as a protective service to children of migrant workers, and to 2,825 children so that adults may engage in or seek employment in order to reduce dependency. Included in this number are children of migrant workers in Montana for the period June 1 through August 30.

### Foster Care for Adults

#### Program Definition:

This program promotes and secures foster care in foster and group homes. These services are available to persons age 18 and over who are unable to remain in independent living situations. Also included are persons in institutions who need community placement through the provision of counseling services to adults upon the initiation or termination of placement. An evaluation assessment of client needs is provided by a process of counseling, recruiting, evaluating and licensing adult foster homes and community homes for the DD.

#### Objective of Program:

To provide supervision to 1,516 adults who are residents in adult foster homes and group homes in order to prevent institutionalization and reduce dependency, and to recruit and evaluate homes for 424 individuals in order to prevent institutionalization.

## Foster Care for Children

### Program Definition:

To provide foster care services for children under age 18 outside their homes for more than 24 hours when their own homes are not available to them. Activities of the program include:

1. Preparatory services to children and families upon initiation or termination of foster care placement.
2. Foster and group home placement services.
3. Counseling services to child, natural and foster families during the individual child's placement.
4. Counseling and supportive services to restore family unity.
5. Reuniting families.
6. Counseling to secure future job training and employment.
7. Counseling for adoptive placement.

This program complies with Section 408 of the Social Security Act.

### Objective of Program:

To provide foster care services to 1,800 children in need of care because of abuse, neglect, or other forms of exploitation, and to provide community based care services for 111 persons inappropriately placed in institutional settings and to prevent such future placements.

## Health Related Services for Adults

### Program Definition:

This program provides services to assist adults in attaining and remaining in an optimum condition of health by assisting in the utilization of necessary medical treatment services. Services of this program include helping people to understand their illnesses, arranging for transportation to and from medical services, working with individuals and family members to assure that medical recommendations are followed, and working with medical practitioners to assure that appropriate services are provided.



### Objective of Program:

Insure that 600 adults are afforded health services in order to prevent dependency and to prevent placement of adults into institutions.

### Health Related Services for Children

#### Program Definition:

Health related services for children are those services for children under age 21 which are related to the Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The EPSDT program is a medical service program for children of AFDC families which is funded through Title XIX. The health related services include informing parents of the program, assisting parents to carry out recommended medical findings through counseling, providing child care and arranging transportation for the initial examination and subsequent follow up visits.

#### Objective of Program:

To provide 1,500 children with early medical and/or health related services in order to detect health problems before they become major medical problems.

### Homemaker Services

#### Program Definition:

Homemaker services include assistance and demonstration in meal planning, preparation and food buying, assistance with doctor and dental appointments, shopping for household items and clothing, clothing repair, light household chores and child management.

#### Objective of Program:

To provide homemaker services to 275 families and 773 adults who are in danger of becoming abused, neglected or exploited and to provide services to 111 adults in order to prevent institutional placement.

### Information, Referral, and Follow Up

#### Program Definition:

This service provides information, to any person on request, regarding Title XX and related programs. Where appropriate, referrals are provided to Title XX and other program resources, and follow up is provided to assure the provision of services requested.



### Objective of Program:

To provide information, referral, and follow up resources to 5,104 persons in order to prevent or reduce dependency, neglect, abuse, or exploitation, and to prevent or reduce inappropriate institutional care, to secure admission to appropriate institutional care or to achieve or maintain self-sufficiency.

### Institutional Placement and Counseling

#### Program Definition:

This program arranges appropriate institutional placement for individuals to nursing homes, boarding homes and personal care homes. Activities include pre-admission screening and monitoring and counseling after placement. In addition to the placement function, this program develops community placement and community care alternatives for persons presently residing in nursing homes. All eligible medical components will be paid for with Title XIX funds.

#### Objective of Program:

To provide appropriate institutional placement for 200 adults, to provide counseling services for 3,355 individuals in nursing homes and to develop placements for 150 persons currently in nursing homes into community placements.

### Legal Services

#### Program Definition:

Legal services include legal counseling, advice, representation and appeal in civil matters, exclusive of criminal, fee generating, probate, and bankruptcy cases.

#### Objective of Program:

To enable 1,000 low income persons to obtain legal services through the Montana Legal Services Association for problems which impede the achievement or maintenance of economic self-support and self-sufficiency, the prevention or remediation of neglect, abuse, or exploitation, prevention or reduction of inappropriate institutional care, and admittance to appropriate institutional care. Specifically, to enable 50 persons to obtain or retain employment, 170 persons to obtain and/or maintain entitlements to Social Security, veterans benefits and other forms of earned entitlements, 180 persons to avoid eviction from rented housing, 500 persons to obtain child support or establish paternity, 100 persons to obtain protection against exploitation by unscrupulous commercial interests, and 50 persons to be admitted or released from nonpenal institutions or to receive appropriate care in such institutions.

## Protective Services for Adults

### Program Definition:

Protective services are services directed at the goal of preventing or remedying neglect, abuse, or exploitation of adults over age 18 who are unable to protect their own interests. Activities of this service include identification; investigation and diagnosis; provision of counseling; arrangement of appropriate alternative living arrangements; assistance in locating medical and legal care, including guardianship; arrangement of protective placement; and the provision of advocacy.

### Objective of Program:

To provide protective services to 2,300 adults, including some DD persons, who are unable to protect their own interests in order to prevent, reduce or remedy neglect, abuse or exploitation.

## Protective Services for Children

### Program Definition:

This program provides services to those under 18 years of age who are harmed or threatened with harm through nonaccidental physical or mental injury, sexual abuse, or negligent treatment or maltreatment. Activities of this program include identification and diagnosis; investigation; determination that the individual is vulnerable or at risk of neglect; abuse or exploitation; counseling and therapy for parental figures and children; securing custody; identifying the need for foster care or adoption; arranging for the provision of services outside the child's own home; and training parents or obtaining training courses for parents.

### Objective of Program:

To provide protective services to 9,160 children in order to prevent or remedy neglect, abuse, or exploitation.

## Family Centered Early Intervention

### Program Definition:

This service provides early intervention for "acting out", "pre-delinquent" and "behaviorally disturbed" children under age 12 and their families as a protective service. Activities of this service include teaching parenting skills in management behavior techniques and teaching children social learning skills. In-home observations are provided as well as consultations to schools.

### Objective of Program:

To provide family teaching services in Region IV only, to 80 families in order to (a) prevent delinquency and serious disturbance in children in these families; (b) prevent or remedy child abuse and neglect by providing these parents with child management skills; and (c) avoid institutional placement by maintaining and treating children in the home.

### Family Planning

#### Program Definition:

Family planning services are comprehensive services directed primarily at preventive health measures and counseling which are aimed at enabling families to voluntarily limit their family size. Family planning services include counseling, patient education, blood tests for anemia, rubella and syphilis, immunization for rubella, blood pressure, height and weight, physical examinations, pap smear, gonorrhea culture, gonorrhea treatment, pregnancy tests, urinalysis for sugar and protein, breast self-examination instruction, diagnosis and treatment of vaginal infection, I.U.D. insertion, dispensation of contraceptive supplies, inter-agency referral for other problems, and day care and transportation services when needed. AFDC clients are served through Title XIX.

#### Objective of Program:

To provide comprehensive family planning services through local Family Planning Clinics to 2,550 persons in order to enable them to voluntarily limit the size of their families.

#### Current Goals and Objectives:

- A. To maintain children in their own homes or in the least restrictive environment.
  - 1. To develop, provide and maintain quality child-centered, family-focused protective services to 7,500 children who are abused, neglected and/or exploited in FY 78-79 and to seek referrals and provide investigation of all children alleged to be neglected with an estimated increase to 8,250 children and to maintain children in their own homes whenever appropriate in FY 80-81.
  - 2. To provide homemaker services to 248 families in order to protect children from possible abuse or neglect in FY 78-79 and to increase homemaker services to 350 families in FY 80-81.



3. To develop a system to insure quality day care to 1,500 children so that parents may engage in or seek employment or training and to 208 children in danger of neglect, exploitation or abuse in FY 78-79 and to implement a sliding scale for day care in which children of parents whose incomes are within 58% of the state median income are eligible to receive day care related to a sliding scale and to increase the rates paid to providers in FY 80-81.
  4. To provide case management services to 100 DD children in FY 78-79 and to increase case management services to 250 other children.
  5. To provide 4,140 children with early medical screening and health related services.
- B. To provide services to children in alternative placement and make permanent placements.
1. To provide the best possible foster care placement to 1,312 children and families in need of substitute care by developing criteria for placement, developing the service plan and using appropriate resources to provide community based services for 100 children placed in institutional settings in FY 78-79 and to provide the best possible placement for each child and family in need of substitute care and reduce the foster care caseload by 10% or 100 children.
  2. To continue to assure that 150 children free for adoption can be placed with an appropriate family in Montana and to provide for the evaluation of 816 non-agency placements as required by law.
  3. To provide subsidized adoption for 40 children with special needs who would otherwise not be adopted; 20 children with a monetary subsidy including sibling groups, and 20 children in need of a medical subsidy in FY 78-79 and to provide for subsidized adoption of an additional 40 children with special needs who would otherwise not be adopted, 20 with a monetary subsidy and 20 with a medical subsidy, bringing the total amount to 80 children in FY 80-81.
- C. To maintain adults in the least restrictive environment.
1. To continue to provide protection to 2,280 adults unable to protect their own interests by identifying, investigating and providing counseling, arranging alternative living arrangements and other services to prevent abuse, neglect or exploitation of adults in FY 78-79.

2. To continue to provide foster care and other services to 714 adults in need to assist them to remain in their communities and to recruit and evaluate homes for 300 individuals to prevent institutionalization.
  3. To provide case management for 1,251 DD adults who are in FY 78-79 and to provide case management in Individual Habilitation Plan meetings to 1,320 DD adults in FY 80-81.
  4. To provide homemaker services to 703 adults to assure them of remaining in their own homes and to provide services to 100 adults to prevent institutionalization in FY 78-79 and to serve an additional 600 adults in FY 80-81.
  5. To continue to provide health related services to 1,692 adults to prevent dependency and placement into institutions in FY 78-79.
- D. To provide services to adults in institutional care.
1. To serve 1,117 residents in long-term care facilities, including counseling, for entrance into and discharge planning from these facilities in FY 78-79 and to serve 3,589 residents, including the development and implementation of policies related to entrance and discharge planning in FY 80-81.
- E. To provide community based services to enhance self-sufficiency.
1. To continue to provide information and referral services to 8,865 persons upon request and to follow up to assure the provision of services requested in FY 78-79.
  2. To continue to enable 1,330 low income persons to obtain legal services for problems which impede the achievement or maintenance of economic self-support and self-sufficiency; to prevent neglect, abuse or exploitation by contracting in FY 78-79.
  3. To continue to provide comprehensive family planning services to 3,000 persons in order to enable them to voluntarily limit the size of their families in FY 78-79.
- F. To provide WIN services.
1. To continue to provide social services in single administrative unit teams in cooperation with staff from Employment Services to 1,500 individuals in order that they may participate in employment or training in FY 78-79.



**TITLE XX AND RELATED FUNDING BUDGET AND ESTIMATED EXPENDITURES**  
 By Program Title, State Fiscal Year 1980  
 July 1, 1979 Through June 30, 1980

	Federal		State Gen. Fund	County Poor Fund	3rd Party	Total
	Title XX	Other				
<b>SOCIAL SERVICES BUREAU</b>						
<b>Staff/Operating -</b>						
Adoption	\$ 110,522	-0-	\$13,768	\$25,570	-0-	\$ 149,860
Day Care	213,807	-0-	76,101	-0-	-0-	289,908
Family Planning	4,096	-0-	159	296	-0-	4,551
Foster Care - Adults	46,152	-0-	5,749	10,678	-0-	62,579
Foster Care - Children	466,115	-0-	58,067	107,839	-0-	632,021
Health Related - Adults	10,097	-0-	1,258	2,336	-0-	13,691
Health Related - Children	8,691	-0-	1,083	2,011	-0-	11,785
Homemaker	699,715	-0-	87,168	161,884	-0-	948,767
Info., Referral & Follow-up	169,545	-0-	19,809	36,787	3,750	229,891
Inst. Placement/Counseling	160,535	-0-	20,000	37,140	-0-	217,675
Protective Services - Adults	370,638	-0-	46,173	85,749	-0-	502,560
Protective Services - Children	1,237,002	-0-	135,073	306,095	-0-	1,678,170
Unmarried Parents	29,976	-0-	3,735	6,935	-0-	40,646
Sub-Total	\$3,526,891	-0-	\$468,143	\$783,320	\$3,750	\$4,782,104
<b>Related -</b>						
XIX (Medicaid)	-0-	307,500	35,875	66,625	-0-	410,000
WIN (Work Incentive)	-0-	320,000	35,555	-0-	-0-	355,555
Training (Title XX, Subpart H)	-0-	60,000	14,000	6,000	-0-	80,000
Indochinese Refugee	-0-	15,500	-0-	-0-	-0-	15,500
Sub-Total	\$3,526,891	\$703,000	\$553,573	\$855,945	\$3,750	\$5,643,159
<b>Contracted/Other Services -</b>						
Day Care	571,250	120,000 (WIN)	445,844	-0-	-0-	1,137,094
Legal Services	75,000	-0-	25,000	-0-	-0-	100,000
Family Planning	206,550	-0-	-0-	-0-	22,950 (Dept. of Health & Env. Sci.)	229,500
Subsidized Adoption	-0-	-0-	30,000	-0-	-0-	30,000
Domestic Violence Grants	-0-	-0-	72,000	-0-	-0-	72,000
Sub-Total	\$4,379,691	\$823,000	\$1,126,417	\$855,945	\$26,700	\$7,211,753

# YOUTH DEVELOPMENT BUREAU

Staff/Operating	254,254	-0-	84,752	-0-	-0-	339,006
Family Centered Early Intervention	81,000	1,675(Training)	27,000	-0-	-0-	108,000
Youth Residential Treatment	124,611	-0-	42,096	-0-	-0-	168,382
Volunteers to Youth	109,800	-0-	-0-	-0-	36,600 (Donated)	146,400
4C's	178,611	-0-	63,750	-0-	31,787	274,148
West Yellowstone (Human Services Coordinator)	3,375	-0-	-0-	-0-	1,125	4,500
Sub-Total	<u>\$751,651</u>	<u>\$1,675</u>	<u>\$217,598</u>	<u>-0-</u>	<u>\$69,512</u>	<u>\$1,040,436</u>

# DEVELOPMENTAL DISABILITIES DIVISION

Staff/Operating	695,945	-0-	219,982	-0-	-0-	879,927
Vocational (Day Services)	2,204,463	100,000(DD Service Act)	1,679,040	-0-	-0-	3,983,503
Transportation	294,582	-0-	224,414	-0-	-0-	518,996
Daily Living Training	917,052	-0-	698,613	-0-	-0-	1,615,665
Respite Care	-0-	-0-	182,184	-0-	-0-	182,184
Training for Parents	-0-	-0-	798,041	-0-	-0-	798,041
Diagnosis and Treatment	-0-	-0-	175,501	-0-	-0-	174,501
Program Expansion (Medicaid)	-0-	505,221	263,752	-0-	-0-	768,973
Training (Title XX, Subpart H)	-0-	225,000	75,000	-0-	-0-	300,000
Sub-Total	<u>\$4,076,042</u>	<u>\$830,221</u>	<u>\$4,315,527</u>	<u>-0-</u>	<u>-0-</u>	<u>\$9,221,790</u>

# ADMIN. & SUPPORT

	757,596	855,174	399,332	459,700	-0-	2,471,802
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# COUNTY ADMIN.

	<u>208,020</u>	<u>101,980</u>	<u>-0-</u>	<u>205,000</u>	<u>-0-</u>	<u>515,000</u>
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# TOTAL

	<u>\$10,173,000</u>	<u>\$2,612,050</u>	<u>\$6,058,874</u>	<u>\$1,520,645</u>	<u>\$96,212</u>	<u>\$20,460,781</u>
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SERVICES PROVIDED

TABLE 3.A

Agency: SRS  
Program: Social Services

ALTERNATIVE COMMUNITY LIVING SERVICES

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
1. Adoption		X					X	
2. Day Care for Child.		X					X	
3. Foster Care, Adults			X	X			X	X
4. Foster Care, Child.		X	X				X	X
5. Health Related Svs. for Adults		X						X
6. Homemaker Svs.	X	X						X
7. Institutional, Placement & Counseling							X	
8. Protective Svs. for Adults		X						X
9. Protective Svs. for Children		X						X

TABLE 3.A

## CASE MANAGEMENT SERVICES

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
1. Adoption	X	X		X	X		
2. Foster Care, Adult	X	X		X	X	X	
3. Foster Care, Children	X	X		X	X	X	
4. Health Related Svcs. for Children	X		X			X	
5. Health Related Svcs. for Adults	X		X			X	
6. Homemaker Svcs.				X			
7. Information, Referral & Followup	X		X			X	
8. Institutional Placement Counseling	X	X					
9. Legal Svcs.		X	X	X			
10. Protective Svcs., Adults		X			X	X	
11. Protective Svcs., Children		X			X	X	
12. Family Centered Early Intervention		X			X	X	
13. Family Planning	X	X	X		X	X	

TABLE 3.A

## CHILD DEVELOPMENT SERVICES

Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
1. Adoption		X				
2. Day Care for Child.	X					
3. Foster Care, Child.	X	X				
4. Health Related Svs. for Children	X		X	X		X
5. Homemaker Service					X	
6. Institutional Placement & Counseling		X		X		
7. Protective Svs. for Children	X	X				
8. Family Centered Early Intervention	X	X			X	

TABLE 3.A

## NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/Day Activities
1. Health Related Svs. for Adults		X	X			
2. Health Related Svs for Children		X	X			
3. Homemaker Services	X					
4. Family Planning			X		X	



# NUMBERS OF PERSONS SERVED

Table 3. B ALTERNATIVE COMMUNITY LIVING ARRANGEMENTS - SOCIAL SERVICES

REGION	In-House Services		CAPACITY FOR MORE			Family Support		CAPACITY FOR MORE			Foster Care		CAPACITY FOR MORE			Group Living		CAPACITY FOR MORE		
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	1461					1178					757					452				
II	2872					1970					815					1091				
III	2773					1452					679					1296				
IV	2273					1616					736					673				
V	2496					1207					574					544				

The following constraints to services apply to most services provided:

1. Need for additional staff and/or better distribution of staff (critical areas are for protective services for children and adults)
2. Need for additional funding
3. Need for additional training
4. Lack of organized constituency or advocacy
5. Lack of interagency coordination
6. Lack of adequate identification of services provided by other agencies

Table 3. B

CASE MANAGEMENT - SOCIAL SERVICES

REGION	Assist- ing with Access			CAPACITY FOR MORE			Follow Along			CAPACITY FOR MORE			Coordina- tion of Services			CAPACITY FOR MORE			Other Services			CAPACITY FOR MORE			
	TOTAL	DD		YES	NO	CONSTRAINT	TOTAL	DD		YES	NO	CONSTRAINT	TOTAL	DD		YES	NO	CONSTRAINT	TOTAL	DD		YES	NO	CONSTRAINT	
I	3370			X			1359			X			2508			X				579					
II	6641			X			2589			X			4653			X				1091					
III	7211			X			2946			X			5461			X				1225					
IV	4621			X			1825			X			3550			X				782					
V	5119			X			2190			X			4311			X				911					

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Table 3. B

CHILD DEVELOPMENT - SOCIAL SERVICES

REGION	Early Intervention			CAPACITY FOR MORE			Counseling of Parents			CAPACITY FOR MORE			Training of Parents			CAPACITY FOR MORE			Other Services			CAPACITY FOR MORE			
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	332					1711					916						1412								
II	769					4732					2244						3745								
III	889					5592					2244						4205								
IV	1015					3508					1729						3030								
V	975					3883					2107						3375								

Table 3. B NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICE - SOCIAL SERVICES

REGION	Asst. w/ Daily Living	CAPACITY FOR MORE			CAPACITY FOR MORE			Other Services			CAPACITY FOR MORE			CAPACITY FOR MORE		
		TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	338											3332				
II	290											2840				
III	145											1417				
IV	221											2163				
V	165											16160				

Section 3

SPECIAL EDUCATION





## SPECIAL EDUCATION

Special Education services are provided by approximately 400 of Montana's 614 local school districts and by 28 special education co-operatives. The Superintendent of Public Instruction, an elected official, is responsible for setting standards for public educational programs and distributing State funds to local districts. The Special Education Unit is the entity within the Office of Public Instruction (OPI) which handles administrative coordination and technical assistance for special education programs. (Refer to table on next page).

The Office of Public Instruction, in accordance with State law (20-7-401, MCA 1979), identifies eleven types of handicaps which may require special educational services: deaf, hard-of-hearing, mentally retarded, orthopedically impaired, other health impaired, emotionally disturbed, specific learning disability, speech/language impaired, visually handicapped, multiply handicapped, and deaf/blind. Developmentally disabled students are counted among many of these categories.

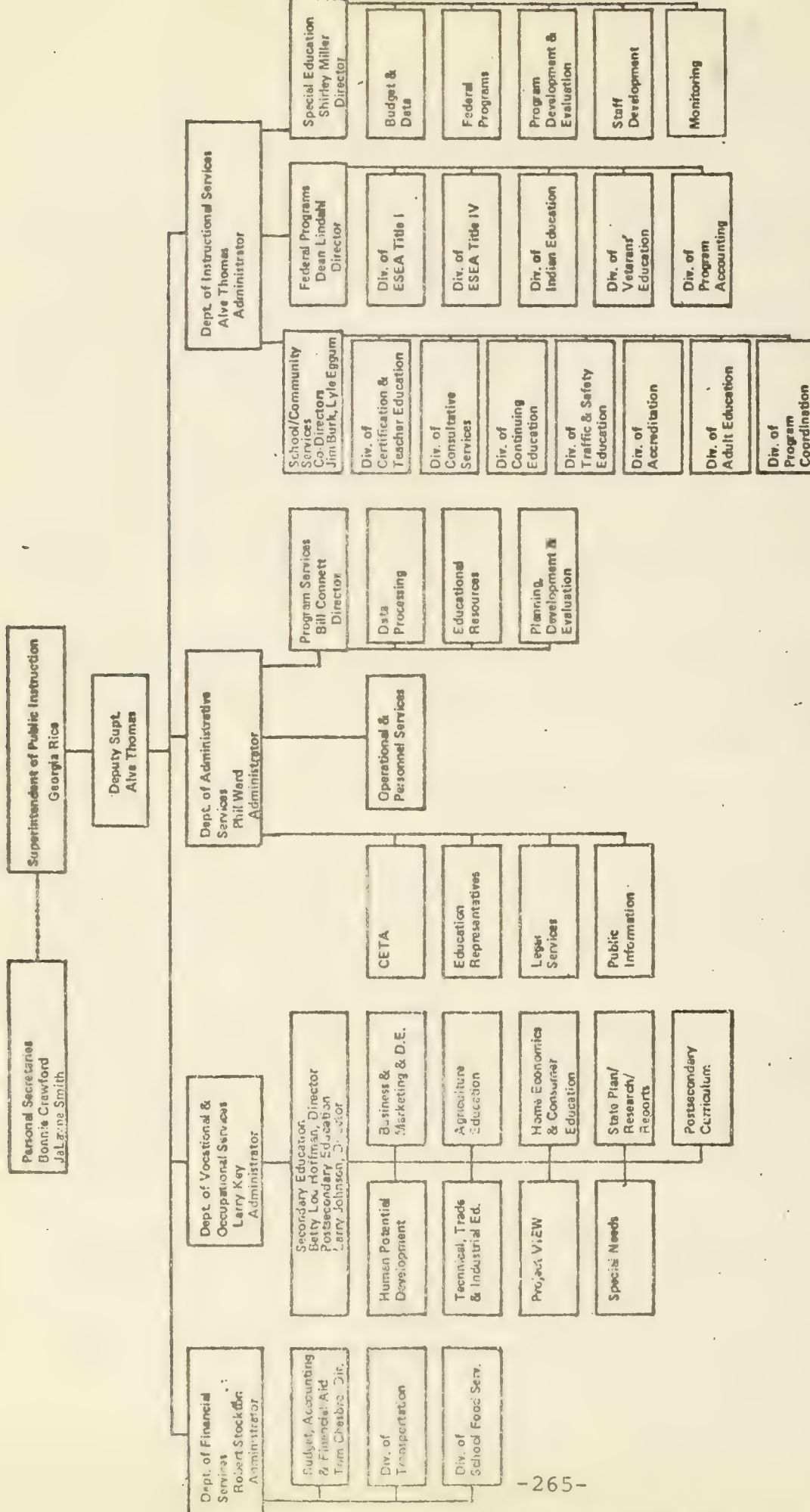
Montana school districts are required by State law (20-7-411) to provide special education for all handicapped children between the ages of 6 and 18 inclusive. Districts may, with the approval of OPI, elect to provide special education services to children between 3 and 5 years old.

Six methods of delivering instructional services to special education students are used in Montana:

1. Resource Instruction and Service: Special education teachers provide instruction either in the handicapped students' classrooms or in separate resource rooms for a portion of the school day. In addition to providing instruction, resource teachers serve as consultants to regular classroom teachers who have handicapped students.

2. Self Contained Classrooms: Special education classrooms are provided for students whose handicapping condition is too severe to allow placement in regular classrooms with resource instructional support. Self-contained special education classrooms generally have between four and twelve students of approximately the same chronological age. A single class may have students with a variety of handicapping conditions as long as the educational needs of each student are met.

3. Cooperative Services: OPI contracts through host school districts for programs which provide special education services to very small districts unable to support their own fulltime programs. Each Cooperative Services staff member serves several school districts and functions as an itinerant resource teacher and consultant. During 1979-80, 28 Cooperative Services Programs were operating.



4. Services to Homebound and/or Hospitalized Students: When a student is hospitalized or, for medically documented reasons, must remain at home, special education services may be provided outside the school.

5. Contracted Services: Special education services are sometimes purchased from the individuals or agencies not employed by or part of the school district.

6. Out-of-District Services: A student may be served outside of his home school district if his district is unable to offer appropriate special education services. The student's home district pays room and board costs if an out-of-district placement involves living away from home. Out-of-district services may be provided outside of Montana if appropriate services are not available in the state.

The Table on the following page shows the number of personnel, by professional category, who were providing special education services in 1979-80. Of the professionals employed, 66% are teachers. Among non-instructional staff, speech pathologists (163 FTEs) and psychologists (94 FTEs) are the largest groups.

Local school districts, with OPI authorization, offer a number of services which supplement special education instructional programs.

Education Screening: Montana Child Find is a project undertaken by OPI and local school districts in an attempt to identify children who are in need of special education. OPI's role in Child Find involves the provision of public information (radio, television, newspaper, posters, mailing, and toll free telephone number) about the availability of screening services. Inquiries are referred to local districts.

Educational Evaluation: Each special education student is evaluated by a Child Study Team prior to placement into a special program. The core team which is required includes: the parent, the special education teacher, the regular teacher, and the principal or a designee. A Child Study Team may also include other professionals whose evaluations are needed to adequately determine the child's educational needs. The Child Study Team devises the annual goals for the Individualized Education Plan (IEP) for the student. The IEP outlines short- and long-term goals as well as the services which are needed to reach the goals. The team reviews and revises the IEP at least annually and a complete re-evaluation of each special education student is done at least every three years.

For further information about the IEP, see Section 8 of this Plan.

SPECIAL EDUCATION PERSONNEL EXPRESSED

AS FULLTIME EQUIVALENTS BY PROFESSION:

1979-1980

<u>TYPE</u>	<u>PROFESSIONAL FTE</u>	<u>AIDES FTE</u>
Teacher-self contained class	233.9	147.3
Resource Room Teacher	432.5	84.2
Itinerant/Consulting Teacher	30.7	9.4
Home-Hospital Teacher	10.5	-----
Voc. Ed. Special Needs Teacher	8	1.1
Work Study Coordinator	10	.5
Adaptive P.E. Teacher	8.2	2
Counselor	8.8	-----
Special Education Supervisor	50.7	4
Speech Pathologist	162.8	2.8
Audiologist	11.4	4.4
Psychologist	92.9	-----
School Social Worker	5.9	-----
Occupational Therapist	4	-----
Physical Therapist	6	-----
Recreation Therapist	1	-----
Nurse	7	-----
Other Non-Instructional	7.5	-----
TOTAL	1098.3	255.7



Transportation: All special education students are entitled to transportation to and from school, regardless of the distance they live from school. The OPI pays parents who drive their children to school from isolated areas not served by school buses.

Room and Board: School districts may pay the room and board expenses for students who must live away from home in order to attend out-of-district educational programs.

Non-Instructional Professional Services: Local school districts and Cooperatives may, with OPI authorization, provide the services of any or all of the following professionals to special education students: special education teachers, speech pathologists, audiologists, social workers, special education supervisors, counselors, nurses, physical therapists, and occupational therapists. Local schools provide these services by: (1) hiring fulltime professionals, (2) sharing professionals with other districts, or (3) contracting for services.

In December, 1979, 12,284 students were receiving special education services in Montana. These students were identified as follows:

1979-80 School Year

12,284 handicapped children

7.8% of total statewide enrollment (K-12) of 158,208

12,284 children identified as follows:

Learning Disabled	5,260	43%
Speech Impaired	3,879	32%
Mentally Retarded	1,642	13%
Multiply Handicapped	642	5%
Emotionally Disturbed	413	3%
Hearing Impaired	140	1%
Orthopedically Impaired	129	1%
Other Health Impaired	111	.9%
Visually Impaired	50	.4%
Deaf	17	.1%
Deaf/Blind	1	.01%



A recently developed evaluation design, coupled with ongoing reporting, auditing and approval procedures, will evaluate and assist local districts in essentially these ways: (1) Programs will be reviewed for compliance with the OPI rules and regulations including those having to do with IEPs, class size, and due process procedures; (2) Programs will be monitored to ensure proper use of federal money; (3) A sample of students' IEPs will be examined and classroom observations made to see that instructional activities are consistent with the IEPs.

The following objectives for 1981 have been developed by the Special Education Unit:

1. Supplement state and local contributions to serve first and second priority handicapped children (unserved school-aged children ages 6 - 18 and handicapped children ages 6-18 within each disability with most severe handicapped receiving an inadequate education).
2. Provide for the continuation of an ongoing statewide handicapped child find system.
3. Provide assistance to LEAs and SOPs for policy development, implementation and compliance/complaint investigation.
4. Provide incentive money to stimulate the development of new pre-school programs for the handicapped.
5. Provide monies to supplement existing educational programs in the state's six state operated programs to insure a free and appropriate public education for all eligible residents.
6. Assist LEAs and SOPs in transporting handicapped students.
7. Support 6.8 FTE personnel in the Special Education Unit, OPI and the activities and administration of the unit.

TABLE 3.A

## SERVICES PROVIDED

Agency: OPI  
Program: Special Education

## ALTERNATIVE COMMUNITY LIVING SERVICES

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
1. Services to Home-bound and/or Hospitalized Students	X							
2. Out-of-District Services			X				X	X

TABLE 3.A

## CASE MANAGEMENT SERVICES

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
1. Resource Instruction & Service		X	X		X	X	
2. Self-Contained Classroom			X				
3. Cooperative Svs.	X		X	X	X		
4. Services to Home-bound and/or hospitalized students				X			
5. Out-of-District Services	X			X	X	X	
6. Education Screening.	X						
7. Education Eval.	X		X		X	X	

NOTE: Contracted Services may include any or all of the above service components of the Priority Service Areas.

TABLE 3.A

CHILD DEVELOPMENT SERVICES						
Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
1. Resource & Instruction Service		X				
2. Out-of-District Services				X		
3. Cooperative Svs.		X				
4. Education Screening	X		X			
5. Educational Eval.				X		
6. Non-instructional Professional Services	X		X	X		

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TABLE 3.A

NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE						
Service	Assisting with Daily Living	Transport- tation	Financial Assistance	Recreation	Training in Personal/Social/ Civic Matters	Work/Day Activities
1. Out-of-District Svs.	X	X	X			
2. Transportation		X	X			
3. Non-instructional Professional Services					X	

# NUMBERS OF PERSONS SERVED

Table 3. B

CASE MANAGEMENT - O.P.I.

REGION	Assist with Access		CAPACITY FOR MORE			Follow Along		CAPACITY FOR MORE			Coordina- tion of Services		CAPACITY FOR MORE			CAPACITY FOR MORE				
	STATE TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	STATE TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	177					**					689***									
II																				
III																				
IV																				
V																				

\*\*Individual figures representing Follow Along Services are not available

\*\*\*Coordination of services column does not include Educational Screening and Evaluation Services due to lack of specific numbers representing these services

FOR SERVICE CONSTRAINTS, SEE PAGE 275

Table 3. B

## CHILD DEVELOPMENT SERVICE

REGION	Statewide total number served		CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE					
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	17181*	** 392																		
II	2321	511																		
III	2493	548																		
IV	2948	648																		
V	2886	635																		

\*Numbers in total column derived from total number of students served multiplied by the percentage of the total population in that region.

\*\*Numbers in DD column represent relative percentage of DD population to the total population in that region.

Figures in both columns appear high in relation to total number served in Montana. However, these breakdowns consider more than one service per individual.



Table 3. B NONVOCATIONAL SOCIAL DEVELOPMENTAL SERVICES

REGION	Other non-instructional related svcs.				CAPACITY FOR MORE				CAPACITY FOR MORE				CAPACITY FOR MORE				CAPACITY FOR MORE				
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	
I	7.5*	7.5																			
II																					
III																					
IV																					
V																					

\*Figures represent total number of students receiving non-instructional services statewide. This is the only breakdown available and is not represented according to Priority Service Area.

The following service constraints apply to all priority service areas unless otherwise specified.

1. Shortage of support personnel (speech therapists, psychologists, OT, PT, etc.) in providing services to handicapped children in smaller school districts.
2. Inability of many child study teams to effect a comprehensive evaluation.
3. Securing related services as specified in child study teams. This is especially pertinent in smaller school districts.
4. Lack of availability of in-state placement options for severely emotionally disturbed children.
5. Legislative elimination (in 1979) of mandatory services for handicapped children under age six and over age eighteen.
6. Difficulty in attracting support personnel to sparsely populated areas.
7. Limitation imposed by the state legislature as to the maximum amount of state funds which could be distributed to local school districts.
8. The need to secure interagency cooperation at state and local levels in providing services to the handicapped.
9. The need to expand the monitoring activities by the Special Education Unit.
10. The need to insure appropriate preservice training of administrators and regular education teachers regarding the handicapped.
11. The need to expand and solidify the development of special education cooperatives throughout the state.
12. The need to provide appropriate inservice training to regular and special educators based on expressed needs.
13. The need to insure the effectiveness of the referral-evaluation-child study team- IEP-placement process.
14. The need to improve the effectiveness of state operated programs.

Section 3

VISUAL SERVICES DIVISION



## VISUAL SERVICES DIVISION

The Visual Services Division (VSD) and the services it provides are authorized by Montana state law (Title 53, Chapter 7, Part 3). The services provided are partially funded by the same federal act (P.L. 95-602) which funds the State Council. For an illustration of the service delivery system through the VSD, see the organizational chart on the next page and the map showing the VSD district offices on the following page. Nine VSD Counselors are housed in these district offices.

### Services Provided

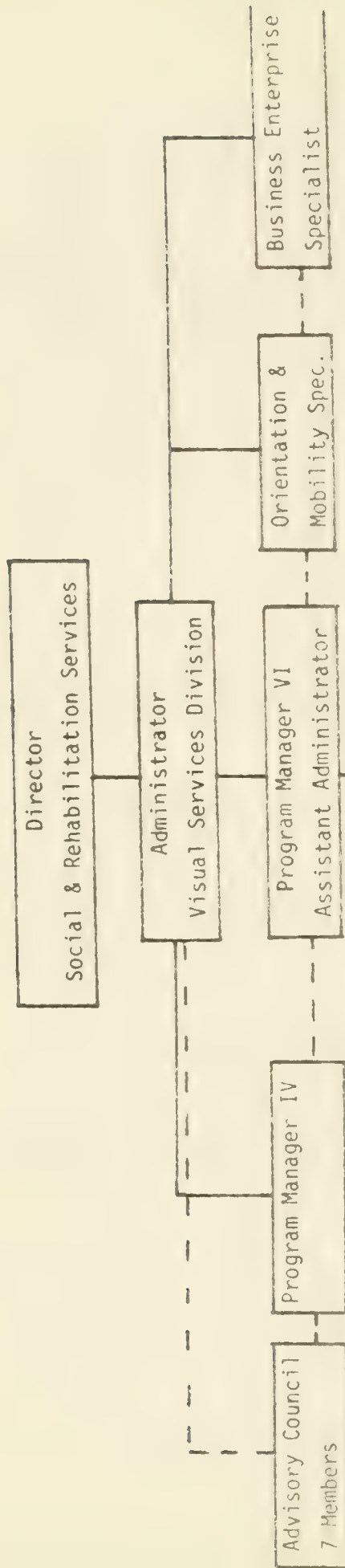
Following is a list of the services available through the VSD to eligible individuals:

1. Evaluation of rehabilitation potential;
2. Counseling, guidance, and referral;
3. Physical and mental restoration services;
4. Vocational and other training services;
5. Maintenance;
6. Transportation;
7. Services to members of a handicapped individual's family necessary to the adjustment or rehabilitation of the handicapped individual;
8. Interpreter services for the deaf;
9. Reader services, rehabilitation teaching services, and orientation and mobility services for the blind;
10. Telecommunications, sensory, and other technological aids and devices;
11. Recruitment and training services to provide new employment opportunities in rehabilitation, health, welfare, public safety, law enforcement, and other appropriate public service employment;
12. Placement in suitable employment;
13. Postemployment services necessary to assist handicapped individuals to maintain suitable employment;
14. Occupational licenses, tools, equipment and initial stocks (including livestock) and supplies; and
15. Other goods and services which can reasonably be expected to benefit a handicapped individual in terms of his employability.

### Eligibility for Services

It is the policy of the Visual Services Division and the Rehabilitative Services Division (Vocational Rehabilitation) that applicants who have a major disability involving their vision will be clients of the VSD. In cases of applicants with multiple disabilities, of which loss of sight is one, the counselors representing these two divisions in the field will make the decision as to which disability is causing the major handicap to employment and thus decide which Division would be involved. The Division accepting the client for services has the responsibility for all needed rehabilitation services to restore the client to gainful employment.

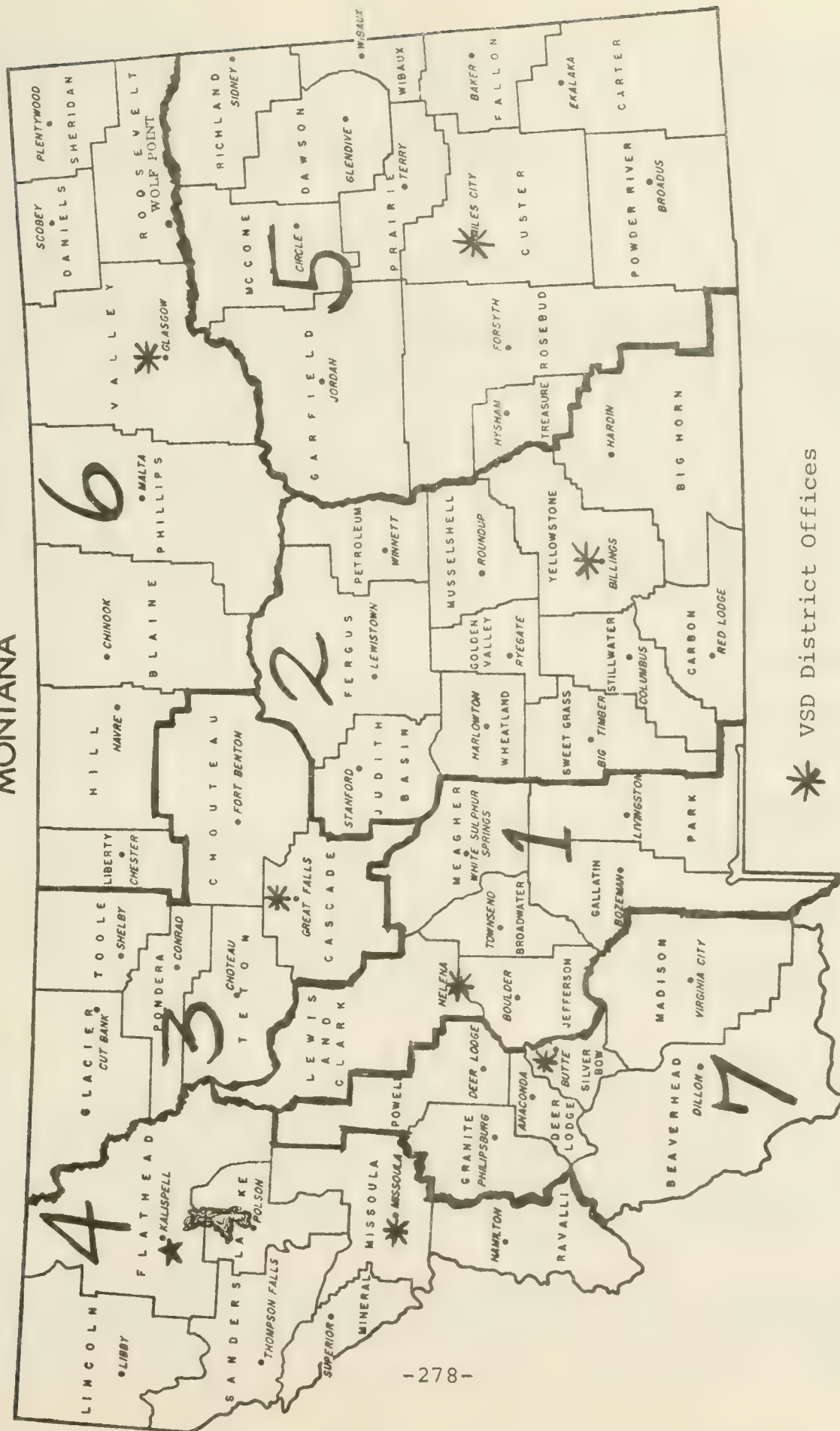




	Helena	Billings	Great Falls	Missoula	Miles City	Glasgow	Butte
	Counselor II Clerk-Steno II	Counselor III Counselor I Rehab. Teacher Clerk-Steno II	Counselor III Rehab. Teacher Clerk-Steno II	Counselor III Rehab. Teacher Clerk-Steno II	Counselor II	Counselor II Clerk-Steno II	Counselor III Rehab. Teacher Clerk-Steno I

**Kalispell**  
Subdistrict Office  
Counselor I  
Clerk-Steno II

FUNCTIONAL CHART  
SHOWING SUPERVISION  
Visual Services Division  
Department of Social &  
Rehabilitation Services  
May 1, 1977



The Rehabilitative Services Division will take care of any visual problems that may occur during the course of the plan of services for any of the clients it has accepted with the following exceptions:

1. A Client who is legally blind is the responsibility of Visual Services Division regardless of any other physical problems.
2. A Client having any condition requiring surgery on one or both eyes will be the responsibility of the VSD.
3. A Client having a condition which will lead to blindness is the responsibility of the VSD.

Applicants who have correctable vision in one eye and are blind in the other are referred first to the VSD. The major factor in determining eligibility is whether a vocational handicap exists. This is determined by the Rehabilitation Counselor with the advice of a medical consultant, if needed. If the applicant meets all three of the requirements for rehabilitative services, he should be accepted for services by the VSD. If the applicant does not meet the eligibility requirements for the VSD, there would be no way he would be eligible for services from the RSD, as the eligibility requirements are the same.

#### Advisory Council

In accordance with federal regulations, the VSD has formed a seven-member Visual Services Advisory Council, composed primarily of consumers of services, to assist with the following activities:

1. program evaluations;
2. program planning and development;
3. development of legislative proposals and budgets;
4. assessment of architectural accessibility of facilities;
5. advice on studies and surveys of the VSD;
6. public information;
7. inservice training and staff development;
8. securing resources of other public and private agencies;
9. affirmative action; and
10. research activities.

#### Current Goals & Objectives

GOAL: For FY 1980 the VSD intends to improve, whenever possible, the quality of existing programs as well as the methods and procedures for implementing programs and to initiate new procedures and practices, as necessary, to enable future expansion of services to those blind and visually impaired individuals who are severely disabled.

The Division fully recognizes that distinctive quality of services can always be improved to more effectively satisfy individual needs of the severely disabled blind or visually impaired populations.

## Objectives:

1. To spare 110 Funding, the Division will consider using the Visual Services Medical (VSM) Program in conjunction with the Visual Services Rehabilitation (VSR) Program. VSM when applicable will become a similar benefit for the VSR.
2. To consider the formation of Task Force Committees within the Division's seven member Advisory Council.
3. To consider formal written cooperative agreements with the Montana Association for the Blind and continue utilizing the Advisory Board of the Association as an unofficial Advisory Council.
4. To develop the Division's In-Service Program to better provide for and satisfy the training needs of professional staff as such needs are identified.
5. Whenever possible, to provide in-service training to significant personnel, professional or non-professional, or rehabilitation facilities, nursing homes, retirement homes, hospitals, doctors offices, volunteer groups, etc.
6. By October 1, 1979, SRS plans to have an On-Line Data Processing System sufficiently operative to enhance the Division's capacity to report on all program and fiscal matters pertinent to and in satisfaction of recommendations made by state and federal auditors.
7. To expand programs to include facilities and Independent Living Rehabilitation activities thereby utilizing more federal funding authorized under P.L. 95-602.
8. To increase and improve cooperative interagency agreements.
9. To seek other resources to enable the continuation of Intensive Orientation Programs (IOPs) - including the continued use of volunteer help.
10. By October 1, 1979, in conjunction with the RSD, to have developed an Operations Manual including policies and procedures.
11. By July 1, 1980, to have new rules and regulations written in view of new regulations under P.L. 95-602.
12. To upgrade, improve and expand the Randolph-Sheppard Program.





TABLE 3.A

SERVICES PROVIDED  
ALTERNATIVE COMMUNITY LIVING SERVICES

Agency: SRS  
Program: VSD

Service	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
Srvs. for family spt.		X						
Technological aides and services	X	X						
Maintenance								X

TABLE 3.A

CASE MANAGEMENT SERVICES

Agency: SRS  
Program: VSD

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
Eval. of Rehab potential					X		
Counseling guidance referral		X					
Physical/Mental restoration			X		X	X	
Employment Placement			X				
Post-Emp. Services				- X	X	X	

TABLE 3.A

NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

Agency: SRS  
Program: VSD

Service	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/Civic Matters	Work/day Activities
Transportation		X				
Voc. training						X
Reader's service				X	X	
Interpreter services	X				X	
Recruitment & Training						X
Occupational support						X

# NUMBERS OF PERSONS SERVED

## ALTERNATIVE COMMUNITY LIVING/CASE MANAGEMENT/NONVOCATIONAL SOCIAL DEVELOPMENTAL

Table 3. B

Agency: SRS Program: VSD	All Services Provided		CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE			CAPACITY FOR MORE					
	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
I	47	47																		
II	67	67																		
III	72	72																		
IV	84	84																		
V	83	83																		
State- wide	354	354																		

Section 3

WARM SPRINGS STATE HOSPITAL



## WARM SPRINGS STATE HOSPITAL

Under existing law, the primary mission of Warm Springs State Hospital (WSSH) is to provide evaluation, care and psychiatric treatment to persons of all ages who are suffering from serious mental illness and who have been duly committed voluntarily, involuntarily, or by court order. This includes:

- a. Seriously mentally ill persons who cannot be economically or adequately managed or treated in the community;
- b. Acutely mentally ill persons whose illness is so severe as to preclude treatment anywhere other than a protective and secure institutional environment;
- c. Sub-acute or chronically mentally ill persons who are considered unplaceable in a less restrictive community setting and whose hospitalization will be prolonged;
- d. Seriously mentally ill aged persons and children for whom appropriate community treatment or residential facilities remain to be developed;
- e. Criminal offenders for whom community evaluation and treatment resources are unavailable or who require security precautions during the period of evaluation and treatment;
- f. Seriously mentally ill persons who cannot afford private hospitalization locally, or many require long-term hospitalization at public expense; and
- g. Mentally ill persons residing in communities served by hospitals lacking inpatient psychiatric units.

WSSH will remain an essential part of the interlocking network of Montana Mental Health Services. The institution is organized as a psychiatric hospital whose primary functions are to diagnose and treat persons with psychiatric disorders, to restore them to an optimum level of functioning, and to return them to the community.

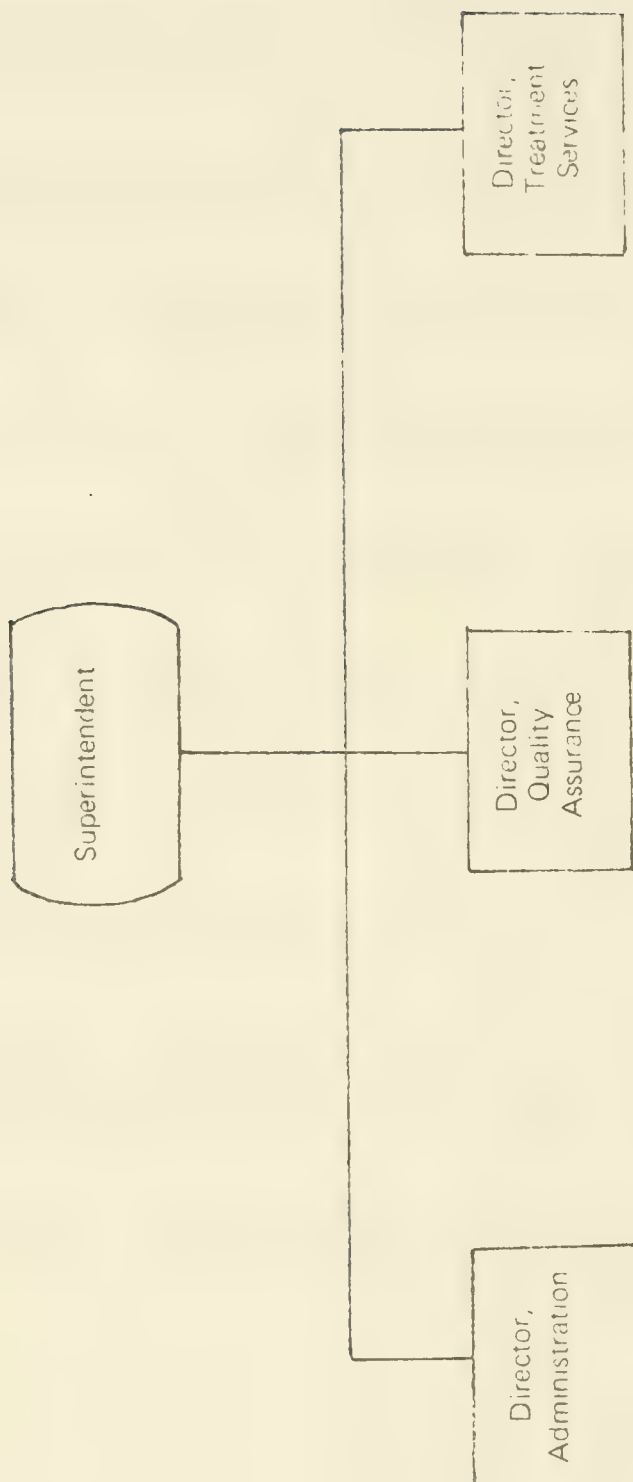
The organization consists of three key functional areas reporting to the superintendent: Administrative Services, Treatment Services, and Quality Assurance Department.

### Administrative Services

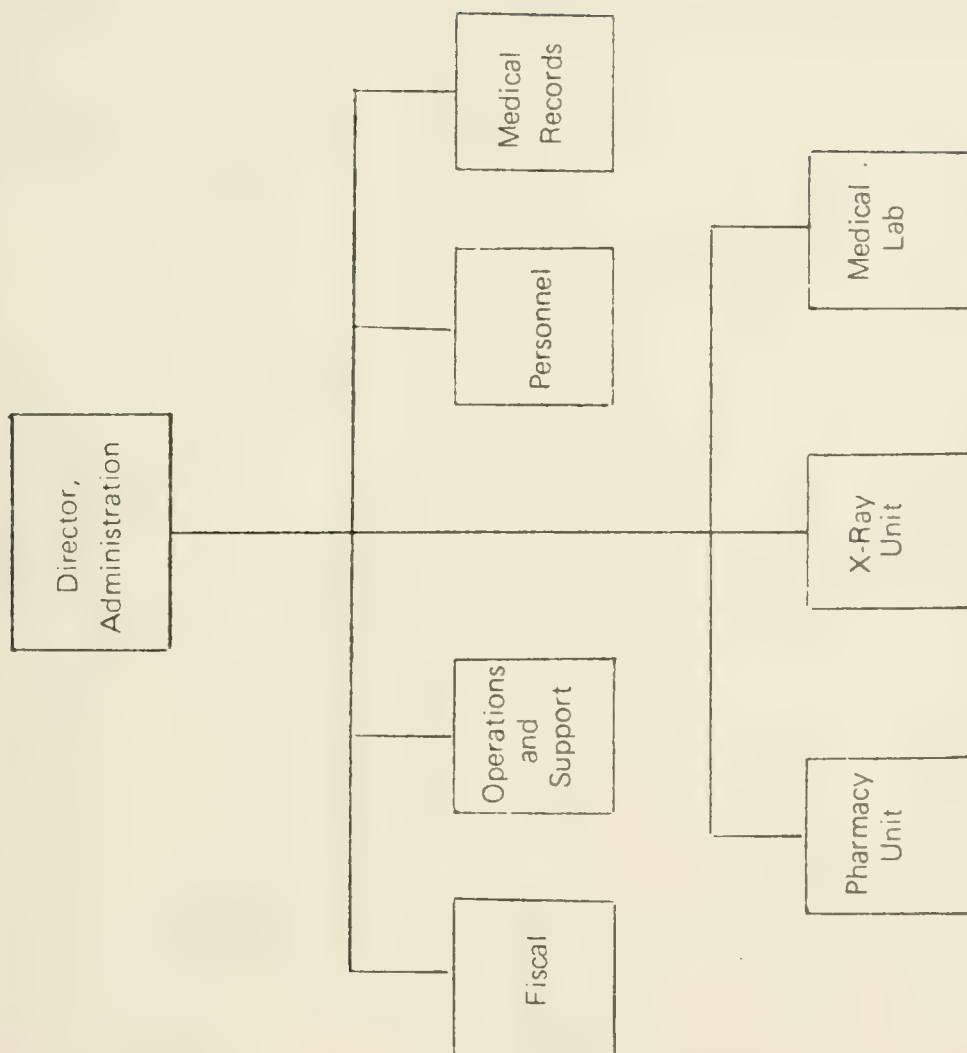
The key functions of Administration are:

1. To ensure the efficient and effective operation of the hospital.

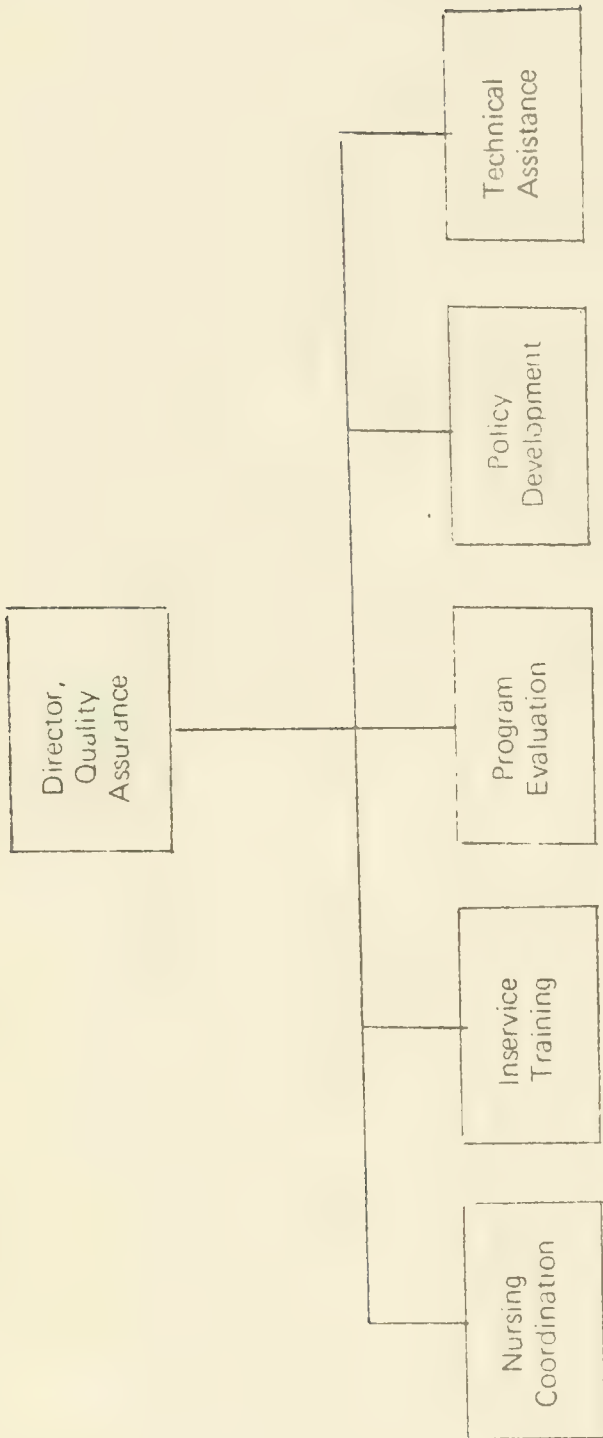




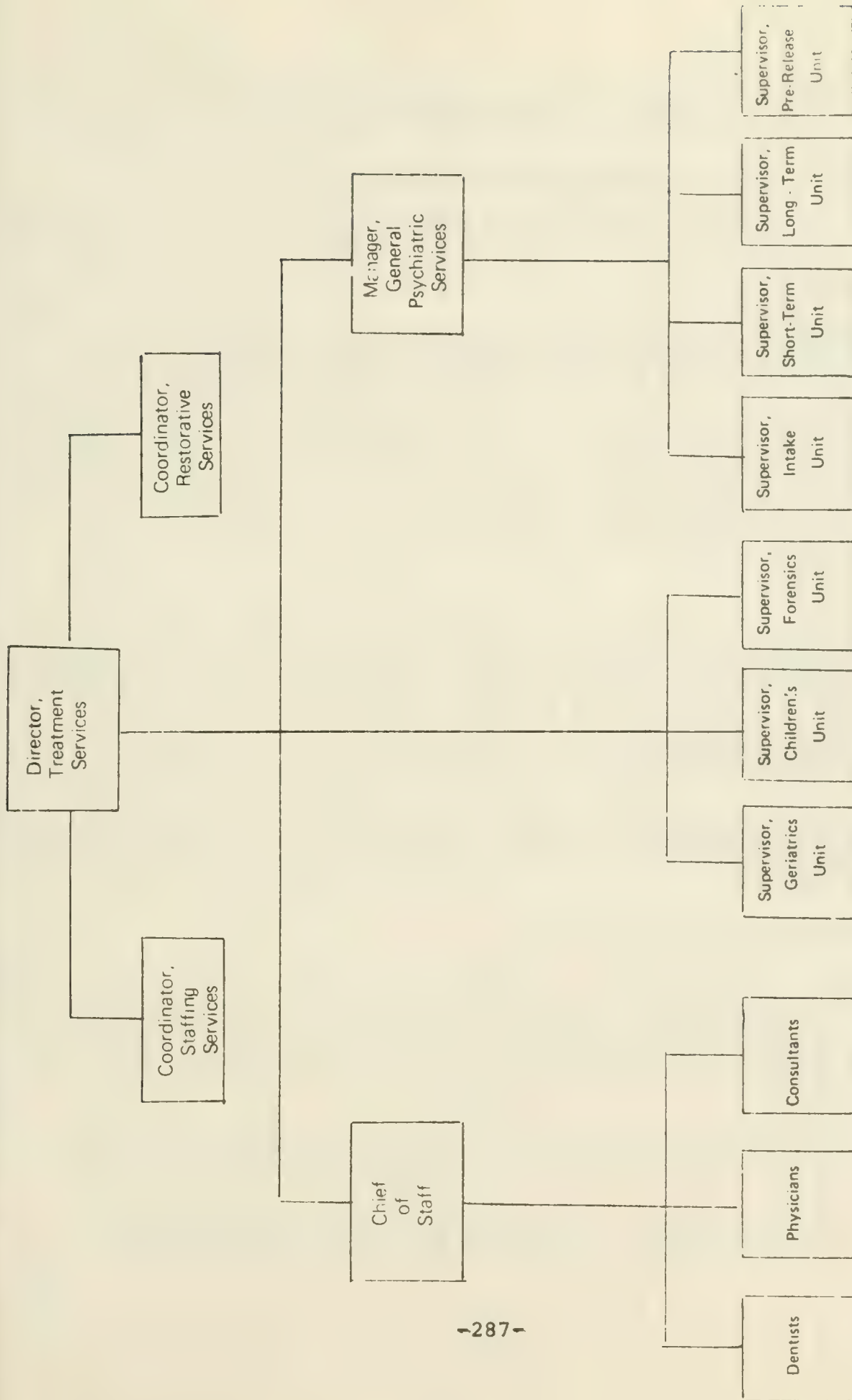
WARM SPRINGS STATE HOSPITAL  
ORGANIZATION



WARM SPRINGS STATE HOSPITAL  
ORGANIZATION  
ADMINISTRATION FUNCTIONS



WARM SPRINGS STATE HOSPITAL  
ORGANIZATION  
QUALITY ASSURANCE FUNCTIONS



2. To facilitate the appropriate use of fiscal, personnel, and physical plant resources.
3. To supply diagnostic and medical support.
4. To develop, maintain, and preserve all documents recording the events of patient care and treatment.

### Treatment Services

Treatment Services provide psychiatric care and treatment to the patient allowing his/her placement according to identified needs and progressive movement through various treatment programs, which emphasize: crisis intervention, evaluation, assessment of treatment needs, intensive treatment, extended care and treatment, and preparation for discharge. Certain coordinative functions are performed by the Restorative Services and Staffing Services sections. However, the major goals of Treatment Services are accomplished through the Specialty and General Psychiatric Treatment units, under the management of Treatment Unit Supervisors.

### The Children's Unit

The intent of the WSSH Children's Treatment Unit under Treatment Services is to provide intensive treatment since the children accepted for evaluation and treatment are predominately considered to be seriously mentally ill persons who require the use of many treatment modalities, including, but not necessarily limited to, behavior modification, individual psychotherapy, group psychotherapy, school programs, and rehabilitation therapies. Essentially, an eclectic treatment approach is utilized since the Montana commitment laws require individualized treatment programming. Thus, the WSSH Children's Treatment Unit endeavors to implement treatment modalities and programs which are tailored to meet the individual needs of the specific child.

### Quality Assurance Department

Quality Assurance is composed of a multidisciplinary team, representing psychology, nursing, social service, and rehabilitation therapies, which provide the hospital with program evaluation, technical assistance, inservice education, policy/procedure development and review, and nursing coordination. The overall goals of the department are:

1. To initiate continuous internal monitoring and assessment of treatment programs and professional practice.
2. To provide guidelines for effective care and treatment consistent with policies of WSSH, legal requirements, regulations, and standards of practice.



3. To provide overall direction and evaluation of specific clinical programs and staff.
4. To coordinate programs and activities of professional and direct care nursing staff in order to maintain safe, efficient, and effective care and treatment.
5. To promote the development, review, and revision of policies and procedures.
6. To implement a process of multidisciplinary staff development and inservice education which will strengthen care and treatment programs.

#### Current Goals and Objectives:

To decrease inappropriate court-ordered admissions to WSSH by 100%.

To provide ongoing evaluation of all program areas in terms of content, effectiveness and costs.

To reduce inappropriate readmissions.

To provide sufficient staff for effective and efficient operation of the hospital as mandated by state and federal regulations, Montana commitment laws and WSSH treatment philosophies.

To continue to improve the content of the medical record and treatment plan through a minimum of 80% compliance with established criteria.

To expand the multidisciplinary staff development and inservice education program to provide at least 80% participation in 8 hours of education annually.

All buildings shall meet fire, safety, and licensure requirements.

To expand and modernize the patient statistical information system.

To decrease the average length of stay of those patients who meet the criteria for discharge.

To implement a program of providing statewide awareness of the services provided by WSSH.

To increase levels of communication and cooperation with outside agencies.

WARM SPRINGS STATE HOSPITAL  
PATIENTS BY SPECIAL UNIT

June 12, 1979

		<u>PRESENT RESIDENTS</u>	
	<u>BED CAPACITY</u>	<u>MEN</u>	<u>WOMEN</u>
Children's Program	35	21	8
Extended Care	175	98	48
Mentally Retarded	28	15	13
Forensic	48	26	0
Geriatric	60	26	21
Intake	24	11	6
Pre Release	24	7	3
Short Term	<u>76</u>	<u>27</u>	<u>24</u>
TOTAL	470	231	123

Total Patients in Hospital 6/12/79 - 354

Total Pateints in Hospital 7/1/75 - 904

SERVICES PROVIDED

TABLE 3.A

AGENCY: Dept. of Institutions  
PROGRAM: WSSH

CASE MANAGEMENT SERVICES

Service	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
Children's Unit		X	X	X	X	X	
Extended Care		X	X	X	X	X	
Forensic & Mentally Retarded	X	X	X	X	X	X	
Geriatric	X	X	X	X	X	X	
Intake	X	X	X	X	X	X	
Pre-Release		X	X	X	X	X	
Short Term	X	X	X	X	X	X	

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TABLE 3.A

CHILD DEVELOPMENT SERVICES

Service	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
Children's Unit	X	X		X		

SERVICES PROVIDED

TABLE 3.A

Service	NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE					
	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/ Civic Matters	Work/Day Activities
Children's Program	X			X	X	X
Extended Care	X			X	X	X
Forensic & Mentally Retarded	X			X	X	X
Geriatric	X			X	X	
Intake	X					
Pre-Release	X			X	X	X
Short Term	X			X	X	X

NUMBERS OF PERSONS SERVED  
WARM SPRINGS STATE HOSPITAL

TABLE 3.B

REGION	All Services		(Bed capacity)		CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE		CAPACITY FOR MORE			
	TOTAL	* DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT	TOTAL	DD	YES	NO	CONSTRAINT
Children's Unit	29	29	X																	
Extended Care	146	?	X																	
Forensic & MR	54	?	X																	
Geriatric	47	?	X																	
Intake	17	?	X																	
Pre-Release	10	?	X																	
Short Term	51	?	X																	

\*Number of residents as of June 12, 1979





SECTION 4

PROGRAM GAPS AND BARRIERS,  
STRENGTHS AND WEAKNESSES,

AND

ESTIMATED SERVICE NEEDS  
OF THE DD POPULATION



Key:  
 S.G: Service Gap  
 U.G: Utilization Gap  
 F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
Agency	SRS		
Service Component	Aging Services		
Priority Ser- vice Area	Case Manage- ment	UG	1. Lack of public awareness of aging services program
		SG	2. Lack of sufficient funds to train people in the aging process and the needs of the elderly.
	Non-Vocation- al Social/De- velopmental	SG	1. Need to expand and develop home health services with all disciplines.
		SG	2. Need to expand support services such as meals on wheels; need for funding for maintenance of transport vehicles.
	Applies to all priority ser- vice areas	FG	1. Lack of funding in most services.
Agency	Dept. of In- stitutions		
Service Component	Boulder River School & Hosp.		
Priority Ser- vice Area	Child Develop- ment	SG&FG	1. All residents need more hours of training than they are receiving; more teachers and aides would make it possible for them to receive additional training.
	Nonvocational Social/Develop- mental	SG&FG	1. Need for additional direct care staff in order to provide for the diverse needs of those residing at BRS&H.

Key:  
 S.G: Service Gap  
 U.G: Utilization Gap  
 F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
	Case Management	SG	1. There is a shortage of personnel to serve residents in occupational therapy.
		SG	2. There is currently a shortage of personnel in speech therapy.
Agency	Dept. of Institutions		
Service Component	Corrections (DD Offenders)		
Priority Service Area	Case Management	SG&FG	1. Lack of funding to provide services to the developmentally disabled incarcerated at Montana State Prison.
Agency	State Board of Education		
Service Component	Deaf/Blind Programs		
Priority Service Area	Case Management	FG	1. 6c funding will not be available after 1980.
		SG	2. Lack of training for Deaf/Blind after age 18.
	Alternative Community Living	FG	1. Not enough funds for training in local education programs.
		SG	2. Montana needs a 12 month program instead of 9.



Key:  
 S.G: Service Gap  
 U.G: Utilization Gap  
 F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
Agency	SRS		
Service Component	Developmental Disabilities Division		
Priority Ser- vice Area	Case Manage- ment	FG	1. Need more funds to provide services to all individuals.
		SG&UG	2. Need to develop a purchase of services contract with appropriate monitoring built in.
		SG&UG	3. Need to develop, implement and maintain nationally-recognized standards for all programs.
	Applies to all PSA	SG	1. Need to determine long-range goals (5-10 years) for the state and each involved agency from a statewide perspective.
		SG	2. Need to implement more effective administrative procedures at all levels, including development of fiscal and management information, contracting procedures, evaluation and research.
		SG&UG	3. Inability to effectively assure quality of services or monitor services provided.
		SG	4. Weakness of administration at all levels.
Agency	MT Health Systems Agency		
Service Component	Health Plan- ning		

Key:  
 S.G: Service Gap  
 U.G: Utilization Gap  
 F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
Priority Service Area	Case Management	SG	1. Montana Deaconess Medical Center in Great Falls should develop a cardiac surgery service by 1985.
		SG	2. End Stage Renal Disease: a. Home self-dialysis programs should be promoted in Montana; b. Geographical accessibility to dialysis facilities should be developed; and c. A statewide prevention program is needed.
		SG	3. Home Health Services: a. By 1982, home health agencies should be established in areas which are not now served; b. By 1985, existing home health programs should be expanded to those areas which are not now served; and c. Educational programs are needed to make the public aware of existing home health services and the need for more.
		SG	4. A coordinated system of providing rehabilitation services in Montana is needed.
		SG	5. The mental health network needs to be better coordinated; prevention programs are needed.
	Nonvocational Social/Developmental	UG&SG	1. During FY 1981, the Mental Health & Residential Services Division should develop quarterly and annual reports on their goals and objectives.
		UG	2. By 1981, a comprehensive prevention plan is needed through satellite mental health centers to include such modalities as parent effectiveness training, behavior modification, community skills and stress in the environment.
Agency	State Department of Health & Environmental Sciences		
Service Component	Handicapped Children's Services		

Key:  
 S.G: Service Gap  
 U.G: Utilization Gap  
 F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
Priority Service Area	Case Management	SG	1. Need better distribution of medical specialists; few specialists in rural areas.
		SG	2. Case management services are limited because all staff are located in Helena.
		SG&UG	3. HCS has low visibility statewide.
	Child Development	FG&UG	1. Interagency agreements are needed in funding and utilizing the Center for Handicapped Children, the Comprehensive Development Center and Developmental Assessment Services.
		FG&UG	2. Lack of a high risk registry for infants who were in intensive care nurseries delays early identification/intervention.
		SG	3. Lack of an evaluation and diagnostic center in Region II
Agency	DHES		
Service Component	Maternal & Child Health		
Priority Service Area	Case Management	SG&UG	1. Lack of coordination of Services.
		SG	2. Lack of available qualified staff.
	Child Development	SG	1. Lack of organized health departments at local level.
		SG	2. Need de-centralization of staff (out of Helena).
		SG	3. Need to develop more multi-disciplinary services.
Agency	Department of Institutions		

Key:

S.G: Service Gap

U.G: Utilization Gap

F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
Service Component	Community Mental Health System		
Priority Service Area	Case Management	SG	1. Lack of mental health programs for: a. chronically mentally ill; b. children; c. the elderly; d. the unserved and underserved; and e. the acutely mentally ill
		SG&FG	2. Need for improved manpower development and training programs.
		UG	3. Rural nature of the state makes service delivery difficult.
	Medical Services	SG	1. Statewide shortage of psychiatrists.
	Alternative Community Living Arrangement	SG&FG	1. Need more community residential facilities.
	All PSA	SG&FG	1. Need for increased consultation, education and prevention services.
Agency Service Component	SRS Public Assistance		
Priority Service Area	Affects all PSA	FG	1. Need more funds to provide a decent standard of living for recipients.
Agency Service Component	SRS Medical Assistance		
Priority Service Area	Alternative Community Living	SG	1. Need for ICF/MRs.



Key:  
 S.G: Service Gap  
 U.G: Utilization Gap  
 F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
	Affects all PSA	FG	1. Need to correct the disparity between allowable amount of payment to providers under Medicaid and what the general public pays for medical services.
Agency	SRS		
Service Component	Region II DD Advisory Council		
Priority Ser- vice Area	Case Manage- ment	SG	1. Need to develop a plan for dealing with the projected special education graduates in Region II over the next biennium.
		SG	2. Need to provide services to individuals on waiting lists who are receiving other DD services.
		SG	3. Need to continue deinstitutionalization of residents from Region II who reside at BRS&H.
		SG	4. Support the development of services for DD people who are in need of generic services not provided through the DDD.
	Alternative Community Living	SG	1. Need to provide services to individuals in group homes who have been identified as ready for semi-independent living.
		SG	2. Need to begin looking at semi-independent living programs in communities needing that service.
Agency	SRS		
Service Component	Region IV DD Council		
Priority Ser- vice Area	Case Manage- ment	SG	1. Need increased services to the cerebral palsied, epileptic and autistic.
		SG	2. A more innovative approach to job preparation, placement and development and/or establishment of business is needed.



Key:

S.G: Service Gap

U.G: Utilization Gap

F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
	Alternative Community Liv- ing	SG	1. Pre-service staff training, particularly for residential service providers must continue to be emphasized.
		SG	2. Although group homes have been very successful for some people, and semi-independent living programs serve others, it is important that viable alternative living arrangements be researched and models designed to serve a variety of needs.
	Child Develop- ment	SG	1. Lack of speech therapists.
	Nonvocational Social/Develop- mental	SG	1. Lack of planned, supervised recreational opportunities.
Agency	SRS		,
Service Component	Region V DD Council		
Priority Ser- vice Area	Case Manage- ment	SG	1. Lack of post-secondary education opportunities for DD persons.
		SG	2. Need for more sheltered employment services.
	Child Develop- ment	SG	1. Need for a prevention (drug and alcohol use, child abuse) public education program aimed at the junior and senior high school level.
		SG	2. Need for early evaluation, counseling, referral and treatment for the DD population.
	Alternative Community Liv- ing	SG	1. Need for more alternative living situations including intervention homes, group homes for all ages and handicaps, nursing homes and ICF/MRs.
		SG	2. Need for more respite care services.
	Applies to all PSA	FG	1. Funding for program expansion and development needed.

Key:

S.G: Service Gap

U.G: Utilization Gap

F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
Agency	SRS		
Service Component	Rehabilitative Services Divi- sion		
Priority Ser- vice Area	Case Management	FG	1. Funding keeps caseload down.
		UG	2. Lack of public awareness.
		UG&SG	3. Counselors have too large caseloads.
		FG	4. Need more money to serve more severely handi- capped population
Agency	State Board of Public Education		
Service Component	School for the Deaf & Blind		
Priority Ser- vice Area	Alternative Community Liv- ing	SG	1. Need for more residential space.
	Applies to all PSAs	SG	1. Need for a year-round school.
		SG	2. Lack of funding for services.
		SG	3. Need for more certified staff.
Agency	SRS		
Service Component	Social Services		
Priority Ser- vice Area	Case Management	SG	1. More staff is needed for child and adult protective services.
		SG	2. Case management for children needs staff addi- tions and some additional training.
		SG	3. Lack of advocacy.
		SG&UG	4. Lack of interagency coordination.

Key:

S.G: Service Gap

U.G: Utilization Gap

F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
	Nonvocational Social/Develop- mental	SG&UG	1. Lack of advocacy or organized constituency.
	Applies to all PSA	FG	1. Lack of funding at all levels.
Agency	Office of Public Instruc- tion		
Service Component	Special Educa- tion		
Priority Ser- vice Area	Case Management	SG	1. Need to insure appropriate training of admini- strative and regular education teachers concern- ing the handicapped - in areas of preservice, in-service.
		SG	2. Shortage of support personnel in smaller school districts.
		SG	3. Inability to effect a comprehensive evaluation by child study teams.
		SG	4. Need for securing related services in smaller districts - as specified by child study teams.
	Child Develop- ment	SG	1. Need for greater availability of in-state place- ment options for severely emotionally disturbed children.
		SG	2. Need to reinstate legislatively eliminated man- datory services for handicapped children under age 6 and over age 18.
		SG	3. Need to expand the monitoring activities by Special Education Unit.
		SG	4. Need to expand and solidify special education cooperatives in Montana.
		FG	5. Legislative limitations on amount of state funds for special education.

KEY:

Table 4.1

S.G: Service Gap

U.G: Utilization Gap

F.G: Fiscal Gap

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
	Applies to all PSA	SG, UG & FG	1. Need to improve the effectiveness of state-operated programs.
		SG	2. Need to improve the effectiveness of the referral-evaluation-child study team-IEP-placement process.
		SG	3. Need to secure interagency cooperation at state and local levels in providing services to the handicapped.
Agency	SRS		
Service Component	Visual Services		
Priority Service Area	Case Manage- ment	UG	1. Some legally blind individuals receiving Social Security benefits under SSDI or SSI have no incentive to train for and/or enter gainful employment. Counseling staff is reluctant to report noncooperation, particularly in cases of SSI recipients. By reporting noncooperative recipients, the necessary rapport between client and counselor suffers and sometimes cannot be restored.
		SG & UG	2. Presently, the Division has limited cooperative agreements. Interagency linkages need improvement in view of P.L. 95-602.
		FG	3. Because of insufficient funding, client and service priorities need to be revised; this is difficult in view of unknown emergencies related to prevention of blindness.
		SG	4. Montana has no rehabilitation facilities having the capacity to adequately serve the totally blind.
		SG	5. The Division is without sufficient staff to adequately serve the blind in the area of orientation and mobility, and has absolutely no specialized staff with which to serve the deaf/blind.

Key:

S.G: Service Gap

U.G: Utilization Gap

F.G: Fiscal Gap

Table 4.1

PROGRAM GAPS & BARRIERS

		Gap/ Barr. Type	Gap/Barrier Description
		UG	6. Establishing or refurbishing vending facilities becomes a neglect of eligible clients needing services from basic program funds, since the Randolph-Sheppard Program development depends upon such funding.
		SG	7. Lack of legal expertise in the area of Randolph-Sheppard is a problem compounded by external demands for new rules and regulations in the process of reapplication as a state licensing agency.
		SG	8. The lack of an ADP system for reporting purpose.
		FG	9. The Division's ability to provide to blind individuals electronic equipment for reading is stymied due to insufficient funding.



Table 4.2

COMBINED RESULTS OF PROGRAM GAPS & BARRIERS

Type of Gap	Case Management	Child Development	Alternative Community Living	Non-Vocational Social/Develop.
Service Gap	42	19	15	14
Utilization Gap	10	3	2	3
Fiscal Gap	8	7	5	5
TOTALS	68	29	22	22



## PROGRAM STRENGTHS AND WEAKNESSES

The following Table 4.3 contains statements about strengths and weaknesses of programs serving the developmentally disabled in Montana as perceived by those who administer the programs.



TABLE 4.3

AGENCY: Department of Institutions

SERVICE COMPONENT: Boulder River School & Hospital

Priority  
Service  
Areas

STRENGTHS:

- |                                       |   |
|---------------------------------------|---|
| 1. Case Management                    | 1. Quality of the staff: well trained and experienced in evaluation of, and the provision of, necessary services to mentally retarded persons of various levels in all major disciplines to the extent that numbers of staff allow.   |
| 2. Case Management/<br>Child Develop. | 2. Quality of Medical Care: both inpatient and outpatient acute and preventive health care provided by both facility staff and a wide range of medical consultants; the coordination of medical and habilitative services for the residents and the cooperative attitude of staff from all the departments. |
| 3 through 7<br>Case Management        | 3. Individual Habilitation Plan Development and Review System.  |
|                                       | 4. Staff Development Training: Pre-service, Boulder Training Center, Advanced Health Care, First-line Management and Advanced Management.   |
|                                       | 5. Management and Accountability Systems: to monitor services being provided and budget control.  |
|                                       | 6. Facility Records, Resident Records, and Documentation system.  |
|                                       | 7. Wide Range of Services Available: Habilitation, Physical Therapy, Occupational Therapy, Psychology, Audiology, Speech Therapy, Recreation, Medical, Dental, Social Services, Education, Religion, Foster Grandparents, Adaptive Equipment.   |

WEAKNESSES

- |                                       |   |
|---------------------------------------|---|
| 1. Case Management/<br>Child Develop. | 1. Inadequate numbers of staff in many developmental programs to provide services needed by each resident.              |
| 2. Case Management                    | 2. Inadequate numbers of support services staff.  |
| 3. All PSA                            | 3. Inadequate amount of inservice training and continuing education for most staff.                                     |
| 4. Nonvoc. Soc/Dev.                   | 4. Living facilities for the population we currently serve are overcrowded even though they meet standards.             |
| 5. Alt. Com. Liv.                     | 5. More involvement in the planning of community services for the DD and in the decision of where residents are placed. |



TABLE 4.3 (Cont'd)

AGENCY: Department of Institutions

Priority  
Service  
Areas

SERVICE COMPONENT: Boulder River School & Hospital (cont'd)

WEAKNESSES (CONT.)

- |                     |   |
|---------------------|---|
| 6 and 7<br>All PSA  | 6. Need improvement of internal communication and carry over of the program effort. |
|                     | 7. Staff turnover is steadily being reduced but a greater reduction is necessary.   |
| 8. Nonvoc. Soc/Dec. | 8. Inability to adequately replace/repair equipment as needed.                      |

REASONS FOR WEAKNESSES

1. Lack of financial resources.
2. Lack of financial resources.
3. Lack of financial resources.
4. Lack of additional smaller living facilities.
5. Current DD service network is not conducive to such a process.
6. Number of people involved, restrictions on the ability for management to initiate necessary changes, etc.
7. Salaries, location, type of work, hours and days scheduled to work, lack of recreational opportunities, inflation, etc.
8. Lack of financial resources.

TABLE 4.3 (Cont'd)

AGENCY: State Board of Education

Priority  
Service  
Areas

SERVICE COMPONENT: Deaf/Blind Programs

STRENGTHS:

- |                                |   |
|--------------------------------|---|
| 1 through 3<br>Case Management | 1. All Deaf/Blind services are under one administration.                  |
|                                | 2. State staff knows all individuals served.                              |
|                                | 3. Monitoring by Mountain Plains Regional Center for Deaf/Blind Children. |
| 4. Alt. Com. Liv.              | 4. Cooperative agreement with schools and group homes.                    |

WEAKNESSES:

- |                                |   |
|--------------------------------|---|
| 1 through 3<br>Case Management | 1. Lack of P.T. and O.T. services.                  |
|                                | 2. Lack of 12 month residential schooling.          |
|                                | 3. Title 6c monies terminate in 1980.               |
| 4. Alt. Com. Liv.              | 4. Lack of funds to train local education programs. |

REASONS FOR WEAKNESSES:

1. Lack of funding.
2. Lack of funding.
3. Lack of funding.
4. Lack of funding.

TABLE 4.3 (Cont'd)

AGENCY: Social & Rehabilitation Services

SERVICE COMPONENT: Developmental Disabilities Division

Priority  
Service  
Areas

STRENGTHS:

- |                            |  |
|----------------------------|--|
| 1 and 2<br>All PSA         | 1. Community based system  |
|                            | 2. Location throughout state, thereby widely and readily available                             |
| 3 and 4<br>Case Management | 3. Based upon developmental approach   |
|                            | 4. Active use of Individual Habilitation Planning system                                       |
| 5. All PSA                 | 5. Use of local citizen input and support  |
| 6. Case Management         | 6. Wide range of services, i.e. birth to death, profound level of handicap to mild level       |
| 7 through 9<br>All PSA     | 7. Increasing focus on more severely and multi-handicapped persons                             |
|                            | 8. Supportive legislation and funding  |
|                            | 9. Willingness of agencies to alter programs, regulations, etc., as needs and knowledge change |

WEAKNESSES:

- |                    |   |
|--------------------|---|
| 1. All PSA         | 1. Gaps in continuum of service   |
| 2. Case Management | 2. Lack of evaluation system to measure, insure and promote quality   |
| 3. Child Develop.  | 3. Lack of emphasis on intervention in early stages; i.e., prevention, at risk child or family, family support. |
| 4. Case Management | 4. Inadequate interagency coordination  |
| 5. All PSA         | 5. Lack of available services for all individuals in terms of numbers and quality.                              |

REASONS FOR WEAKNESSES:

1. Lack of funds, inability of system to develop all components quickly at quality level.
2. Lack of expertise, level of currently available technology, low level of priority.
3. Relationship to deinstitutionalization priority placed on other more evident problems.
4. Poor administration
5. Lack of funding, poor administration

TABLE 4.3 (Cont'd)

Priority Service Areas	AGENCY: Department of Institutions
	SERVICE COMPONENT: Eastmont Training Center
	<u>STRENGTHS:</u>
1 and 2 Case Management	1. A total developmental program for each resident.
	2. A functioning residential habilitation program.
3. Nonvoc. Soc/Dec.	3. A well maintained high quality physical plant
4 and 5 Case Management	4. Dedicated, well trained staff.
	5. Excellent community support.
	<u>WEAKNESSES:</u>
1 and 2 Case Management	1. Lack of appropriate community programs to serve the residents residing in the facility.
	2. The need for additional staff and funds to expand institutional habilitative and developmental programs to provide optimum services to each resident.
	<u>REASONS FOR WEAKNESSES:</u>
	1. Services presently offered in the community are designed to serve individuals with more functioning ability than our residents.
	2. Additional funds and staff were not authorized to the facility to provide optimum services.

AGENCY: State Dept. of Health & Environmental Sciences

SERVICE COMPONENT: Maternal & Child Health Bureau

Priority  
Service  
Areas

STRENGTHS:

1 and 2  
Case Management

1. Ability to provide services statewide to families and children through a wide variety of programs such as WIC, Family Planning, Well Child Clinics, Child Abuse project, Maternal & Infant projects, etc.

2. All but four counties have some MCH programs available.

3. Child Development

3. MCH programs have a strong primary prevention component.

4 through 6  
Case Management

4. MCH programs are well coordinated on the local level.

5. Access to MCH programs is local and easy.

6. MCH programs offer reliable referrals for other available services

WEAKNESSES:

1 through 3  
Case Management

1. Coordination of services (WIC, Family Planning and Child Health) with other agencies.

2. Lack of qualified staff and organized health departments at local levels.

3. MCH needs a more multidisciplinary approach.

REASONS FOR WEAKNESSES:

1. Interagency agreements have not been developed.

2. Local funding is not adequate for the development of more local health departments and, in some areas, such development is not viewed as a need.

3. Funding has been directed toward supporting efforts on the local level rather than used to obtain adequate number of professionals at the state level to deal with the development of a multi-disciplinary approach.



AGENCY: State Department of Health & Environmental Sciences

SERVICE COMPONENT: Handicapped Children Services

Priority  
Service  
Areas

STRENGTHS:

1 through 6  
Case Management

1. Provisions of payment for medical and rehabilitative services for eligible children ages birth to 21.
2. High quality medical care, i.e., all physicians must be board certified or board eligible in specialty areas.
3. Minimal amount of eligibility criteria.
4. Experienced and caring staff.
5. HCS provides a good referral mechanism.
6. Participation in ICCHC\* in trying to coordinate services to children.

WEAKNESSES:

1 through 4  
Case Management

1. HCS has low visibility statewide.
2. HCS has no field staff.
3. Lack of an adequate high risk registry.
4. Interagency agreements are needed in funding and utilization of Montana Center for Handicapped Children, Comprehensive Development Center, and Developmental Assessment Services.

REASONS FOR WEAKNESSES:

1. Have not had pamphlet or other handout material to advertise services in 5 years.
2. No funding or FTEs.
3. No money - confidentiality design of a system that is adequate for the needs of several agencies.
4. The concept of interagency agreements is low and thus has not been developed. Work on such agreements is in progress at this time.

\*Interagency Coordinating Committee on Handicapped Children

TABLE 4.3 (Cont'd)

AGENCY: Social and Rehabilitation Services

SERVICE COMPONENT: Public Assistance

STRENGTHS:

This service is available to all persons who meet the eligibility requirements.

WEAKNESSES:

Public Assistance does not receive enough funds to provide a decent standard of living for recipients.

AGENCY: Social & Rehabilitation Services

SERVICE COMPONENT: Medical Assistance

STRENGTHS:

Permitting the client free choice of medical provider.

WEAKNESSES:

The Medicaid Program pays medical fees which are much below the fees paid by the general public.

Priority Service Areas	AGENCY: Social & Rehabilitation Services
Applies to all PSA	SERVICE COMPONENT: Rehabilitative Services Division
1 through 3 Case Management	<u>STRENGTHS:</u>
	Responsive and trained staff
	<u>WEAKNESSES:</u>
	<ol style="list-style-type: none"> <li>1. Insufficient funding for required case service and additional staff.</li> <li>2. Insufficient travel funds</li> <li>3. Job placement of handicapped</li> </ol>
	<u>REASONS FOR WEAKNESSES:</u>
	<ol style="list-style-type: none"> <li>1. Federal budget appropriation</li> <li>2. Energy crisis</li> <li>3. Lack of staff and high unemployment</li> </ol>

TABLE 4.3 (Cont'd)

Priority Service Areas	AGENCY: State Board of Public Education
SERVICE COMPONENT: School for the Deaf and Blind	
STRENGTHS:	
1 and 2 Child Develop.	<ol style="list-style-type: none"> <li>1. Parent-Infant intervention programs at birth for families with deaf, blind, or deaf/blind babies. Services available on a statewide basis with coordination from Montana School for the Deaf and Blind.</li> <li>2. Preschool-Kindergarten through Grade 12. Curriculum for deaf and blind students. Mainstreaming for both handicaps in Great Falls Public Schools on an individual plan as per P.L. 94-142.</li> </ol>
3. Case Management	<ol style="list-style-type: none"> <li>3. Regular educational program with residential facility available for students placed at MSDB through the Child Study Team process.</li> </ol>
Case Management	<p>WEAKNESSES:</p> <p>Funding process for programs and staff to serve statewide.</p> <p>REASONS FOR WEAKNESSES:</p> <p>Budget process is political and on a 3-year ahead basis which makes funding restrictive in terms of programmatic goals.</p>

Priority Service Areas	AGENCY: Social & Rehabilitation Services
SERVICE COMPONENT: Social Services	
STRENGTHS:	
Applies to all PSA	<p>Statewide coverage; all staff trained in priority services; for the most part, quality services are provided in priority areas; priorities established in planning process involving input from all levels of staff.</p>
Case Management	<p>WEAKNESSES:</p> <p>Lack of case management for children on a statewide basis.</p> <p>REASONS FOR WEAKNESSES:</p> <p>Insufficient staff</p>

Priority Service Areas	AGENCY: Office of Public Instruction
	SERVICE COMPONENT: Special Education Unit
	<u>STRENGTHS:</u>
1 through 6 Case Management	<ol style="list-style-type: none"> <li>1. The agency has been able to assemble a staff of qualified and competent professionals.</li> <li>2. There is strong administrative support from the Superintendent of Public Instruction and her staff.</li> <li>3. There exists a cooperative and helpful attitude among state level agencies.</li> <li>4. The agency provides general guidelines for local school districts to plan, organize and operate special ed. programs.</li> <li>5. Close coordination is effected with local school districts regarding the funding and programming of special ed. activities.</li> <li>6. Utilization of federal funds provided under Part B of the Education of the Handicapped Act. This includes the assistance provided to the local school districts, state operated programs and a number of priority projects.</li> </ol>
7. Child Develop.	7. Development of inservice programs based on expressed needs of regular and special ed. personnel.
8. Case Management	8. The performance of on-site monitoring visitations to special ed. programs throughout the state.
9 and 10 Child Development	<ol style="list-style-type: none"> <li>9. The performance of an ongoing child find program.</li> <li>10. Stimulation of interest in the development of local school district preschool programs.</li> </ol>
11. Case Management	11. Implementation of special ed. cooperatives whereby smaller school districts are able to receive a full range of special ed. services.
	<u>WEAKNESSES:</u>
1 through 3 Case Management	<ol style="list-style-type: none"> <li>1. The absence of written agreements among agencies which influence special ed. programs at state and local levels.</li> <li>2. The limited resources to conduct more extensive on-site monitoring visitations.</li> <li>3. The ceiling placed on the amount of state funds which have been made available to local school district special ed. programs. This limit was enacted by the last state legislature.</li> </ol>



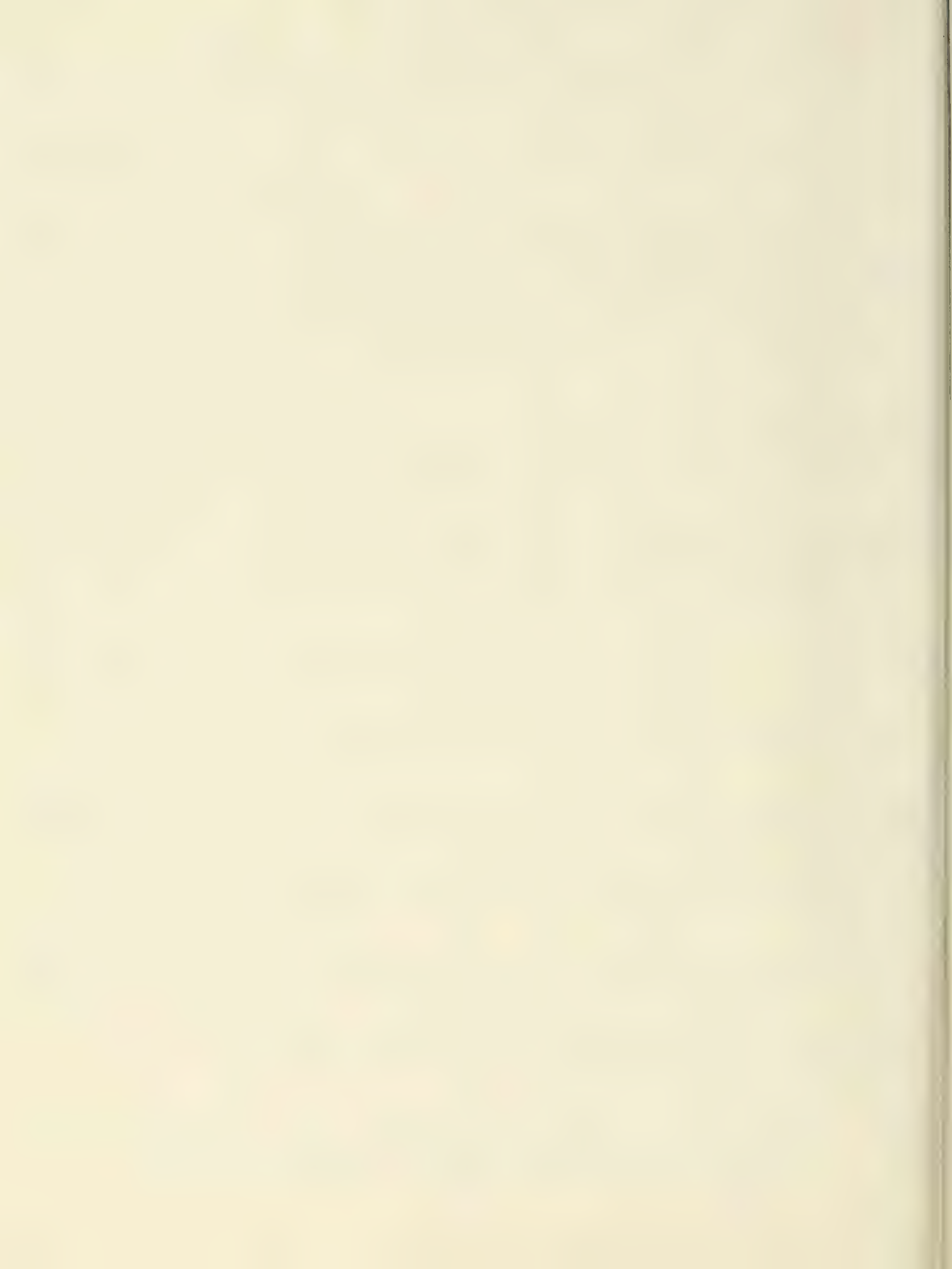
TABLE 4.3 (Cont'd)

Priority Service Areas	AGENCY: Department of Institutions
	SERVICE COMPONENT: Warm Springs State Hospital
	<u>STRENGTHS:</u>
1 and 2 Case Management	<ol style="list-style-type: none"> <li>1. Individualized Treatment Programs are developed for every patient based upon specific patient needs and promoting the patient's successful return to community living.</li> <li>2. Implementation of multidisciplinary staff development and inservice education with at least 80% participation in eight hours of education annually.</li> </ol>
	<u>WEAKNESSES:</u>
1. Nonvoc. Soc/Dev.	1. Patient educational and vocational training programs (especially children) require additional materials and educational staff to comply with federal regulations.
2. Case Management	2. Direct care nursing staff formulae on the Intensive Treatment Unit, Extended Treatment Unit, and Long Term Care Unit should be increased to reflect number of wards within unit, changing treatment concepts and demands, and percentage of acute and sub-acute psychotic patients.
3. Nonvoc. Soc/Dev.	<ol style="list-style-type: none"> <li>3. Additional psychiatric aide positions (15 FTE) should be established, which can be assigned to:               <ol style="list-style-type: none"> <li>a. escorting and sitter responsibilities;</li> <li>b. areas of sudden, unexpected population increases; and</li> <li>c. volatile situations requiring emergency intervention and greater staff concentration.</li> </ol> </li> </ol>
4 and 5 Medical Services	<ol style="list-style-type: none"> <li>4. Psychiatrists should be increased by at least three positions to meet recognized ratios, with competitive salaries established.</li> <li>5. Treatment facilities and specialized staff are not available to adequately treat non-psychotic sexual offenders and other sociopathic individuals who are court-ordered for treatment.</li> </ol>
6 through 8 Nonvoc. Soc/Dev.	<ol style="list-style-type: none"> <li>6. Patient participation in community activities has been reduced due to the reduction in the number of drivers.</li> <li>7. Funding should be provided to bring in qualified educators to conduct educational programs designed to increase staff expertise and awareness of new approaches in psychiatric treatment.</li> <li>8. All buildings do not meet standards of life/safety codes.</li> </ol>
9. Case Management	9. Present funding does not reflect actual inflationary increases. Cost-of-living increases were only funded at 88.6%.

TABLE 4.4

## COMBINED RESULTS OF PROGRAM STRENGTHS AND WEAKNESSES

	P R I O R I T Y   S E R V I C E   A R E A			
	Alternative Community Living	Case Management	Child Development	Non-Vocational Social/Developmental
STRENGTHS	9	49	15	9
WEAKNESSES	7	33	7	12



## ESTIMATED SERVICE NEEDS OF THE DD POPULATION

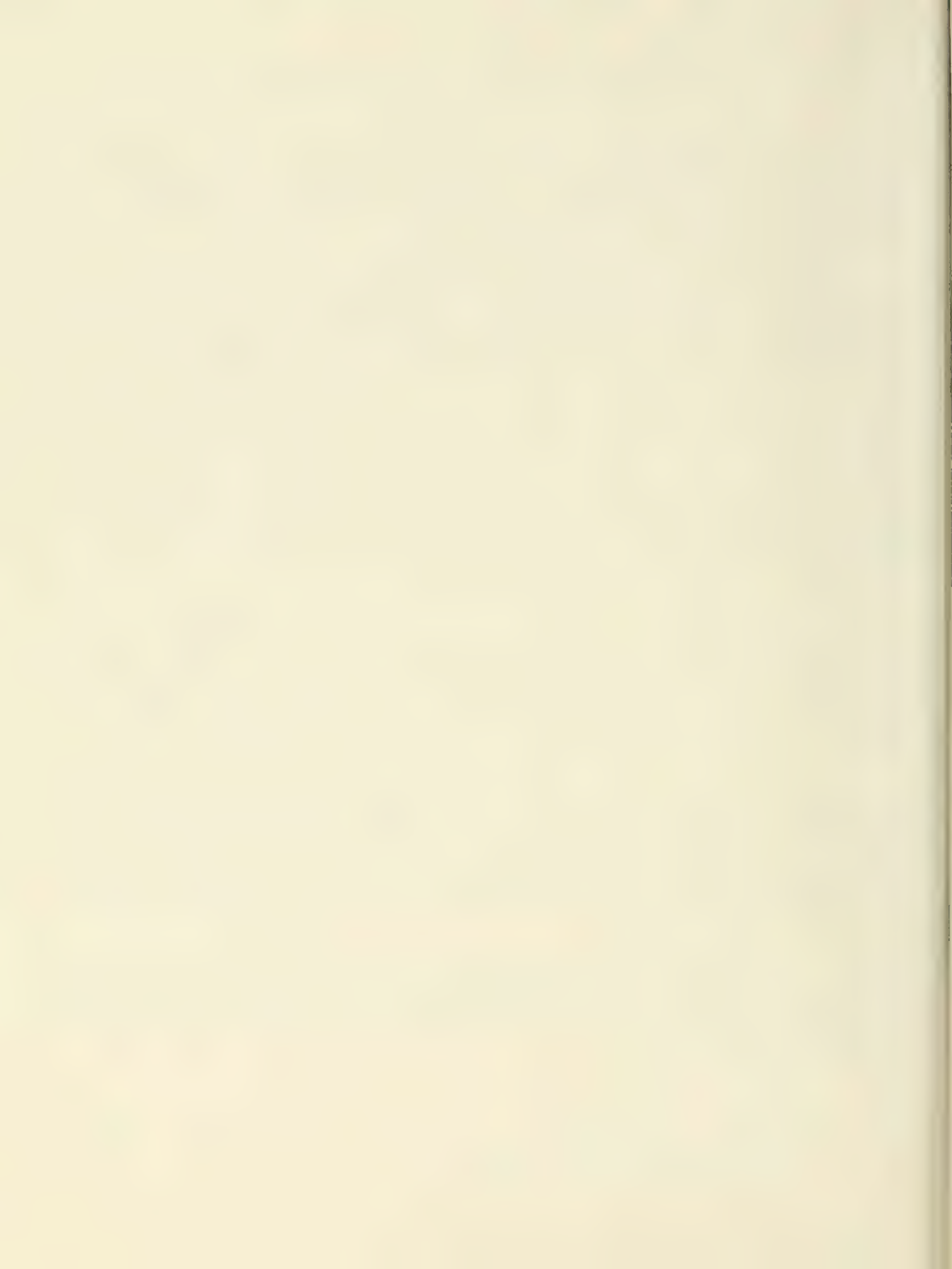
The following pages, Table 4.5, identify the estimated service needs of the DD population in Montana. For the most part, Table 4.5 does not contain any numbers of DD persons needing specific services. The reason for this is because such numbers are not available and were not provided by the programs included in this plan.

During the data collection process for the plan, the State Council attempted to identify the developmentally disabled population being served in Montana by requesting information on DD persons served from all agencies whose programs are included in the plan. None of the agencies surveyed could provide figures for the numbers of people they serve who could be identified as developmentally disabled according to P.L. 95-602. The reason for this is apparently that, since none of the state programs have any reason to comply or identify with the DD definition contained in that federal law, they understandably have no reason to separate the recipients of their services in this manner in their files. It was simply too large a task to ask the agencies to go through every case file to determine which of the recipients of their services have functional limitations in three or more of the seven areas of life activity specified in P.L. 95-602, presuming they would even record information on their clients' disabilities or handicaps, which many programs do not.

It was, therefore, left to the State Council to estimate the number of DD persons in the state. The method for estimating the DD population is spelled out in Section 2 of the plan. Since the total number arrived at, 12,403 DD persons in Montana, is itself an estimate, we feel we would be drifting further and further away from accuracy by going beyond an estimate of the number of persons to be served by even further estimating services they individually need.

Recognizing that this inability to specifically identify the DD population in Montana is probably the greatest gap in services in the state, the first page of Table 4.5 is intended to indicate that this identification process, and a precise identification of services available to and needed by those persons, is the most serious "service gap" and one which affects all DD persons in the state. The total number of persons indicated on the first page of Table 4.5 is the estimated number of DD persons in Montana as indicated in Section 2.

For the remainder of the pages of Table 4.5, no indication of numbers of DD persons needing specific services is given. Rather, the remainder of the Table indicates only service needs perceived by the programs themselves and was extracted from Gaps and Barriers shown in Table 4.1.





SERVICE NEEDS OF DD POPULATION

TABLE 4.5

CASE MANAGEMENT SERVICES

Service Needs	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
State Totals*	12,403		12,403				12,403
Region I	1,618		1,618				1,618
Region II	2,354		2,354				2,354
Region III	2,527		2,527				2,527
Region IV	2,980		2,980				2,980
Region V	2,924		2,924				2,924

\*Applies to the total estimated number of DD persons in the state

TABLE 4.5 (Service Needs as Perceived by Programs)

## CASE MANAGEMENT SERVICES

Service Needs	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
Soc. Svs: More staff for protective svcs. child & adult	X						
SS: Staff additions & trning for cas. man. of children	X						
SS: Advocacy				X			
OPI: Interagency coordination	X		X				
OPI: Training for adm. & regular ed. teachers concerning handicapped.	X		X				
OPI: Shortage of support personnel in small solid. districts.				X			
OPI: Need to insure a comp. CST Evaluation.	X	X	X	X	X	X	X
OPI: Need to secure related svcs. in sch. dist. per CST recommendation.				X			
HCS: Better distribution of specialists	X	X		X		X	X
HCS: Cas man. svcs. are limited because all staff are in H-100.	X	X	X		X	X	

TABLE 4,5 (Service Needs as Perceived by Programs)

## CASE MANAGEMENT SERVICES

Service Needs	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
HCS: Has low visibility statewide	X		X				
VR: More money to srv. less severely handicapped	X	X	X	X	X	X	
DDD : More funds to provide srvs to all individuals	X	X	X	X	X	X	
DDD : Purchase of srv contract w/ monitoring included							X
DDD : Develop; implement & maintain natnl standards for all programs							X
Region II & IV DD Councils: A plan to deal w/special ed grads.	X						
Region II Council: Provide srvs to individuals on waiting lists	X						
Region II DD Council: Addtl deinstitutionalization of Region II resdts at BRS&H	X						
Region II: More generic srvs for DD	X						

TABLE 4.5 (Service Needs as Perceived by Programs)

Service Needs	CASE MANAGEMENT SERVICES (Cont.)					
	Assisting w/Access	Consultation w/ Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along
Region IV: Increased svcs to CP, epileptic, & autistic	X	X	X	X	X	X
Region IV: Job prep., placement & development/establishment of business for DD	X	X	X	X	X	X
Region V: More sheltered employment facilities	X					
HSA: By 1985 develop cardiac surgery svcs. in Great Falls	X		X			
HSA: Develop home self renal Dialysis programs	X		X	X		
HSA: Need greater accessibility to dialysis facilities	X		X			
HSA: Need statewide renal disease prevention program	X		X			
HSA: By 1982 Home Health Agencies should be established in unserved areas	X			X		
HSA: Better awareness by public of existing home health services	X		X			
HSA: A coord. system of providing rehab services			X			

**TABLE 4.5 (Service Needs as Perceived by Programs)**

**CASE MANAGEMENT SERVICES (Cont.)**

Service Needs	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
HSA: Mental Health network needs coord.			X				
VR: Funding keeps VR caseload down	X						
VR: Lack of public awareness of VR svcs.	X						
VR: Counselors have too large caseloads	X	X	X	X	X	X	
MCH: Need Coord. of svcs.			X				
MR Institution (BRSH): Need occupational therapists	X						
MR (BRSH): Need more speech therapists	X						
MH: Need programs for chronically mentally ill children, elderly & acutely mentally ill.	X						
Aging Svcs: Need more public awareness	X						
Aging Svcs: Addtnl. funding to train in aging process & needs of elderly	X						



Table 4.5 (Service Needs as Perceived by Programs)

CASE MANAGEMENT SERVICES							
Service Needs	Assisting w/Access	Consultation w/Client/Family	Coordination of Services	Support Services	Monitoring of Client Progress	Follow-Along	Evaluation of Svcs. Provided
Deaf/Blind: Need 12-month program	X		X	X	X	X	
Deaf/Blind: Need more training after age 18	X		X	X	X	X	

TABLE 4.5 (Service Needs as Perceived by Programs)

## CHILD DEVELOPMENT SERVICES

Service Needs	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
Region IV Council: Need Speech therapists	X		X	X	X	
Region V Council: Prevention (drug & alcohol use, child abuse) education program	X					X
Region V Council: Early evaluation counseling, referral & treatment		X		X		
OPI: Greater availability of in-state placements for Emotionally Disturbed Children	X					
NOPI: Need to reinstate legislative mandate services for those under 6 and over 18	X		X	X		X
OPI: Expand monitoring by Special Ed. Unit	X					
OPI: Expand Special Ed. cooperatives	X		X			
OPI: More funding for Special Ed	X	X	X	X	X	X
HCS: interagency agreements with D & E programs in state	X	X	X	X	X	
HCS: High risk registry for infants	X		X			X

TABLE 4.5 (Service Needs as Perceived by Programs)

CHILD DEVELOPMENT SERVICES (CONT)						
Service Needs	Early Intervention	Counseling of Parents	Early Identification	Diagnosis & Evaluation	Training of Parents	Prevention
HC's: D & E services in Region II need	X	X	X	X	X	X
MCH: Organized Health Departments at local level	X	X	X	X	X	X
MCH: Better staff dis-tribution	X	X	X	X	X	X
MCH: Develop multi-disciplinary services	X	X	X	X	X	X
RRSH: Institutionalized need more training than they are receiving	X	X	X	X	X	X
Deaf/Blind: Need P.T. & C.T. Services	X	X	X	X	X	X

TABLE 4.5 (Service Needs as Perceived by Programs)

## ALTERNATIVE COMMUNITY LIVING SERVICES

Service Needs	In-House Services	Family Support	Foster Care	Group Living	Respite Care	Staff Training	Placement	Maintenance Services
Med. Asst: ICF/MRs	X			X		X	X	
Region II DD Advisory Council: Semi-Independent Living facilities	X			X		X	X	
Region IV DD Advisory Council: Pre-service staff training particularly for residential services						X		
Region IV DD Advisory Council: Research on viable alternative living conditions	X		X	X	X			
Region V DD Advisory Council: Alternative Living situations	X		X	X	X			
Region V DD Advisory Council: More respite care services					X			
School for the Deaf/Blind: More residential space	X			X				
Deaf/Blind: Need funding to train local education agency personnel	X	X		X		X	X	X

TABLE 4.5 (Service Needs as Perceived by Programs)

## NONVOCATIONAL SOCIAL-DEVELOPMENTAL SERVICE

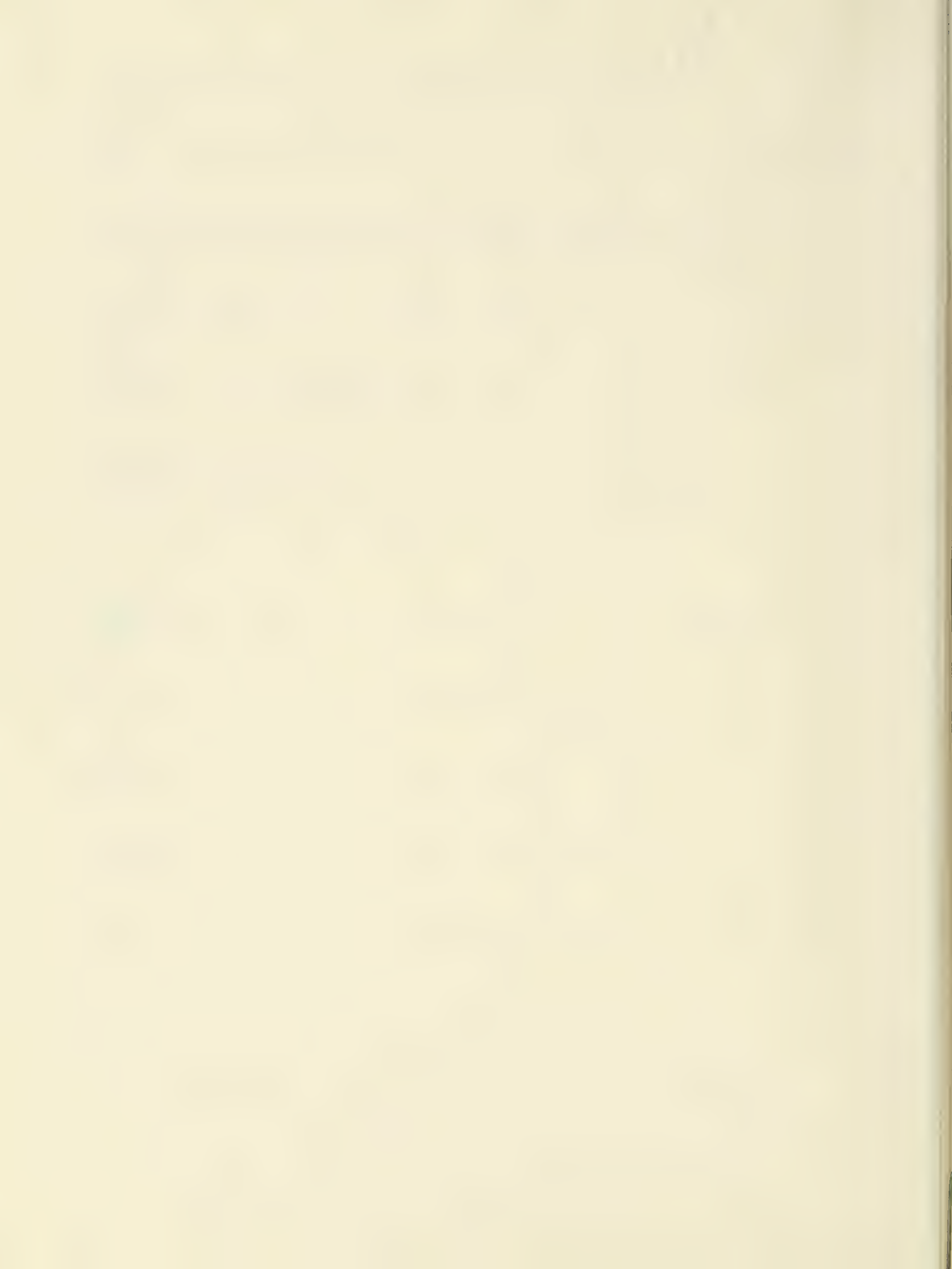
Service Needs	Assisting with Daily Living	Transportation	Financial Assistance	Recreation	Training in Personal/Social/ Civic Matters	Work/Day Activities
MH: Need to develop quarterly and annual reports on goals and objectives	X				X	X
MH: Need Prevention plan through satellite mental health centers	X				X	
Region IV DD Advisory Council: Planned, supervised recreational opportunities				X		
WMR Institution (BRSH): Additional direct care staff	X					
Aging Services: Expand support services	X	X				
Aging Services: expand home health services	X					



TABLE 4.5 - Service Needs as Perceived by Programs

The needs stated below affect all priority service areas:

1. Medical Assistance: Need to correct the disparity between allowable amount of payment to providers under Medicaid and what the general public pays for medical services.
2. Public Assistance: Need more funds to provide a decent standard of living for recipients.
3. DDD:
  - a) determine long-range goals (5-10 years) for the state and each involved agency from a statewide perspective.
  - b) implement more effective administrative procedures at all levels, including development of fiscal and management information, contracting procedures, evaluation and research.
  - c) effectively assure quality of services or monitor services provided.
4. Region V DD Advisory Council: Need funding for program expansion and development.
5. Social Services needs funding at all levels.
6. OPI: needs to
  - a) improve the effectiveness of state-operated programs.
  - b) improve the effectiveness of the referral-evaluation-child study team-IEP-placement process.
  - c) secure interagency cooperation at state and local levels in providing services to the handicapped.
7. Aging Services needs funding at all levels.
8. School for the Deaf and Blind needs:
  - a) year-round school.
  - b) funding for services.
  - c) more certified staff.
9. Deaf/Blind Programs will lose all Title 6c monies after 1980.



SECTION 5

OBJECTIVES AND BUDGET



Table 5.1

PLAN YEAR OBJECTIVE

1. Goal:

To advocate for the continued implementation of a comprehensive statewide system of rural services for the DD.

2. Three-Year Objective:

By Fiscal Year 1983, to have appreciably improved the statewide DD system by means of focusing on services most appropriate to rural areas.

3. Plan Year Objective:

To review and utilize the data and resulting recommendations of the Council-sponsored 1980 analysis of the effectiveness of the statewide DD system (recommendations due January 16, 1981)..

4. Plan Year Objective Activities:

- a. Prioritize recommendations;
- b. Develop strategies for utilization of recommendations;
- c. Develop proposed interagency agreements directed toward agency roles to carry out the recommendations;
- d. Develop timelines for implementation;
- e. Initiate implementation; and
- f. Fund projects and programs which will assist with implementation.

5. Outcome Indicators:

Achieving the objective contained in #3 by means of the Activities outlined in #4.

6. Plan Year Funding:

State:	\$20,833
Federal:	\$62,500
Total:	\$83,333

7. Priority Service Area:

Rural Services for the Developmentally Disabled

8. State Program and Agency:

State Council





Table 5.2

PLAN YEAR OBJECTIVE

1. Goal:

To assist in interagency coordination and development of residential alternatives for children and youth.

2. Three-Year Objective:

To develop additional alternatives to provide more models for residential services and to serve an increased number of children.

3. Plan Year Objective:

To further develop residential services for nine children and to provide support for four residential programs for 19 children.

4. Plan Year Objective Activities:

- a. Provide training to enable children to complete 70% of the Individual Program Plans specified within their Individual Habilitation Plans.
- b. Conduct no less than three formal and two informal training programs for each child.
- c. To provide training to each staff person to enable 90% criterion in the competency based training program.

5. Outcome Indicators:

Summary reports on achievement of objectives which are to be completed on June 30, 1981.

6. Plan Year Funding:

State:	\$ 33,333
Federal:	\$100,000
Total:	\$133,333

7. Priority Service Area:

Child Development Services

8. State Program and Agency:

Developmental Disabilities Division/SRS



## A. ALLOCATIONS TO STATE AGENCIES BY SOURCE OF FUNDS

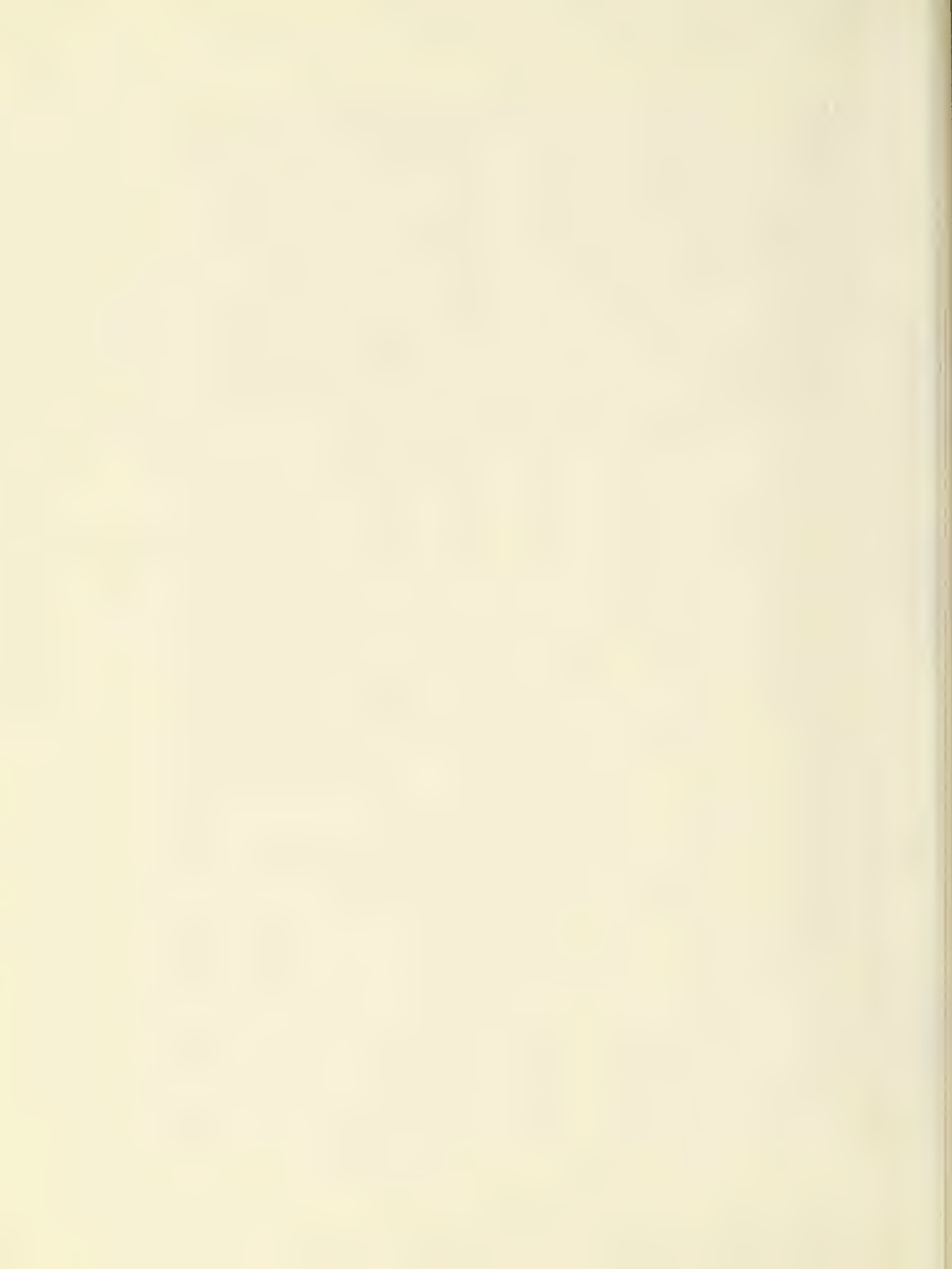
Designated State Agencies	State	Non-Federal Funds		Total (2+3+4)	Federal* Funds	Total (5+6)
		Local	Non-Profit			
1	2	3	4	5	6	7
	\$ 67,107	\$ 20,833		\$ 87,940	\$ 250,000	\$ 337,940
Total	\$ 67,107	\$ 20,833		\$ 87,940	\$ 250,000	\$ 337,940

## B. ALLOCATIONS TO STATE AGENCIES BY PURPOSE

Designated State Agencies	Total federal* & non-federal	Planning		Adminis- tration	Areas of Priority services				
		Council	Other		Case Mgt.	Child devel.	Altern. living	Non- voc.	Other*
1	2	3	4	5	6	7	8	9	10
	F \$ 250,000	\$ 80,590		\$ 6,910		\$ 100,000			\$ 62,500
	NF \$ 87,940	\$ 26,864		\$ 6,910		\$ 33,333			\$ 20,833
	F \$								
	NF \$								
	F \$								
	NF \$								
	F \$								
	NF \$								
Subtotals									
Total	\$ 337,940	\$ 107,454		\$ 13,820		\$ 133,333			\$ 83,333

\* Basic Formula Grant Funds under P.L. 95-602

\*Rural DD Services



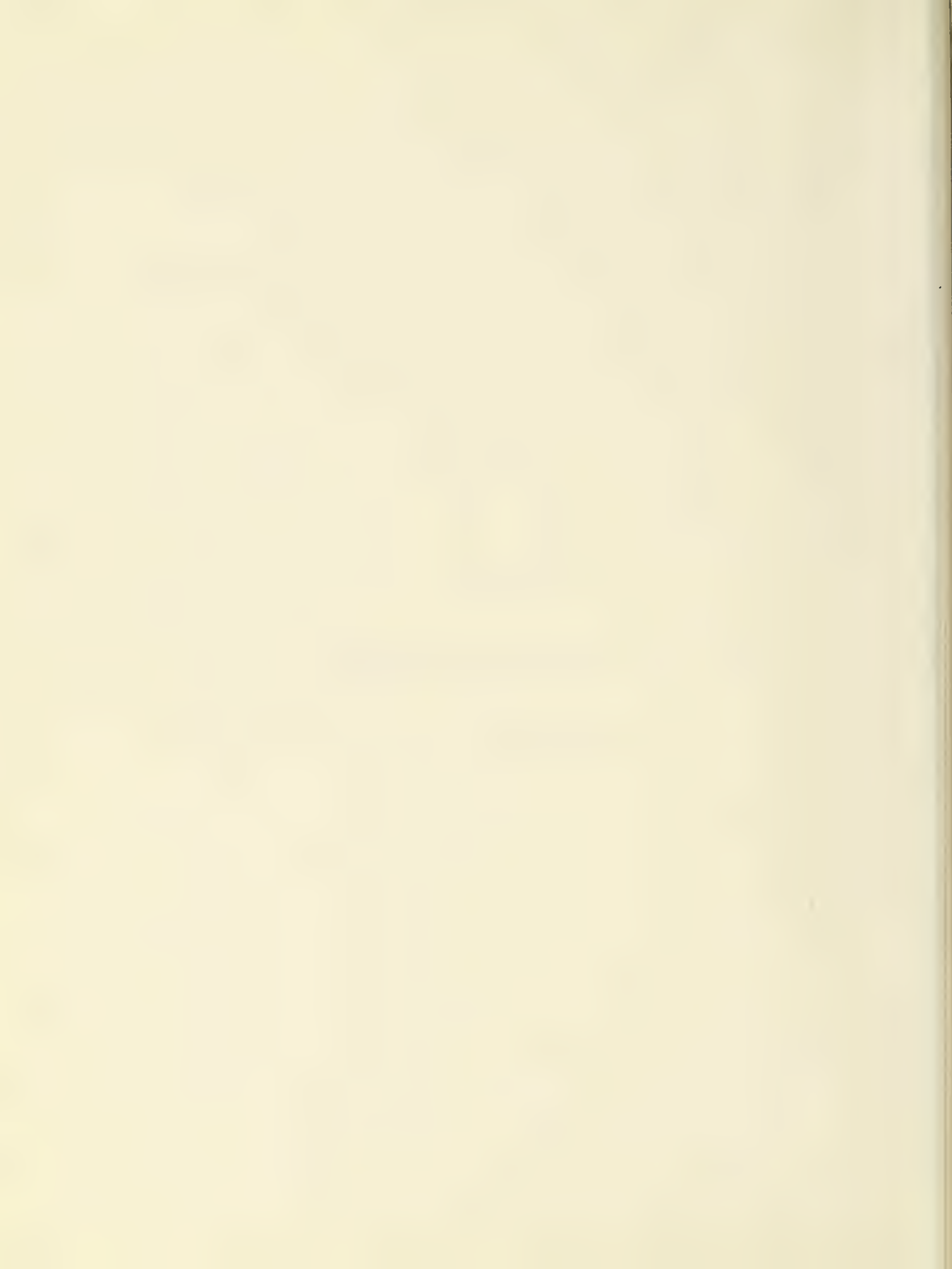


SECTION 6

PROFESSIONAL ASSESSMENT

AND

EVALUATION PLAN ASSURANCE



## CERTIFICATION OF DD PERSONNEL

Table 6.1 illustrates the types of certification available for professionals who work within Montana's DD system. Some additional explanation is necessary, however, concerning programs administered by the following agencies:

Developmental Disabilities Division, SRS: The Developmental Disabilities Division Client Programming Technical (DDCPT) certification is the product of an extensive curriculum which is geared toward teaching the principles and application of Behavioral Analysis. Currently, most staff of DDD providers are either enrolled in the certification program or have already completed it. The DDCPT curriculum is the primary training structure through which the Regional Clinical Trainers of the Division's Technical Assistance Section deliver training. Students completing the DDCPT may apply for three credits from the University of Montana and Western Montana College.

Planning for the future (by July 1, 1980) includes a certification which will be available through the Technical Assistance Section in Epilepsies and Medications. The certificate will identify a staff person as someone who meets the Montana State Board of Nursing definition of "trained" staff who may assist and supervise the self-administration of medications by clients within the community-based DD program. A self-instructional manual has been published and distributed by the Technical Assistance Section to teach all necessary information required.

Developmental Disabilities Division, SRS and Mental Health and Residential Services Division, Department of Institutions: These two agencies jointly certify a category of personnel called "Professional Person". Both the name and the purpose of this type of certification follows mandates of the Montana DD commitment laws (53-20-102 and 53-21-102, M.C.A 1979) under the provisions of which developmentally disabled and mentally ill persons are committed to state institutions. During the commitment procedures, there are some circumstances under which the services, directions or judgment of a "professional person" are required. The stated purpose of certification for professional persons, according to Montana administrative rules, is as follows:

"to recommend to the district court the most appropriate habilitation plan or treatment plan for an individual who is or may be found to be developmentally disabled or mentally ill based upon his evaluation of the individual when a commitment to a residential facility is being sought for that individual; and

to be responsible for assuming the development and implementation of an assigned resident's individual habilitation

plan or treatment plan when employed within a residential facility for that purpose..."

Requirements for certification as a professional person can be found in Appendix A.

Special Education Unit, OPI: All teachers in special education in the public schools in Montana are required to have a Special Education Endorsement on their Montana Teaching Certificate. Speech pathologists are licensed in Montana and individuals who work in the public schools in this capacity must either hold this license or qualify under strict regulations for Speech Technician.

For a more comprehensive explanation of requirements for personnel who work within Montana's special education programs, see Appendix B.

School for the Deaf and Blind, State Board of Public Education: This agency has adopted standards for its staff which go beyond those required for other special education teachers in the state. The standards adopted, those of the Council on the Education of the Deaf, contain requirements specific to the teaching of the deaf. See Appendix C for a copy of these standards.

Rehabilitative Services Division, SRS: Although Rehabilitation Counselors are not licensed or certified in Montana, some are accredited by the National Rehabilitation Counselors Association. The RSD also requires that all facilities with which it contracts be accredited by C.A.R.F. and Administrative Rules adopted by the RSD (see Appendix D) contain professional standards required for health practitioners and others with whom the RSD contracts.

Handicapped Children's Program, SDHES: HCS will not pay for services rendered unless they are provided by board certified or board eligible specialists.

Generic Services: The following health professionals are all required to be licensed under Montana state law:

- dentists
- hearing aid dispensers
- physicians
- nurses
- nursing home administrators
- optometrists
- osteopathic physicians
- pharmacists
- physical therapists
- psychologists
- speech pathologists and audiologists

Only three of those groups of professionals - nursing home administrators, optometrists and pharmacists - are required to take continuing education courses as a condition of re-licensure.

Occupational Therapists must be recognized by their National Board in order to qualify for employment in Montana.



TABLE 6.1

## CERTIFICATION OF DD PERSONNEL

Service	Type of Agency Providing Service	Name of Licensure or Certification (asterisked if required)	Certified By
Institutions for the Mentally Retarded	State	*Physician *Dentists *Dental Hygienist *Registered Nurse *Licensed Prof. Nurse *Psychologist *"Professional Person" *Occupational Therapist *Physical Therapist *Speech Therapist	St. Bd. of Med. Examiners (lic.) St. Bd. of Dentists (lic.) St. Bd. of Dentists (lic.) St. Bd. of Nursing (lic.) St. Bd. of Nursing (lic.) St. Bd. of Psychology (lic.) SRS/Dept. Inst (certif.) Natl. Bd. of O.T. (certif.) St. Bd. of P.T. (lic.) State Bd. of Speech Therapy and Audiology (lic.) St. Bd. of Speech Therapy & Audiology (lic.) St. Bd. of Nursing Home Administrators (lic.) St. Bd. of Pharmacists (lic.) St. Bd. of Education (certif. with Special Ed. endorsement)
Institutions for the Mentally Ill	State	Same professionals and requirements as above	
Community Residential Facilities for the DD	Private Non-Profit	DDCPT	SRS (certification)
Community Residential Facilities for the MI	Private Non-Profit (CMHC)	N/A	
Vocational Rehabilitation Counseling	State	Rehab. Counselor	Natl. Assn. R.C. (cert.)

a - licensure required dependent on grade level of position

TABLE 6.1 (CONT'D)

Service	Type of Agency Providing Service	Name of Licensure or Certification (astericked if required)	Certified By
Sheltered Workshops	Private Non-Profit	*accreditation	C.A.R.F.
Work Activity Centers Day Activity Centers	Private Non-Profit	DDCPT	SRS
Medical/Health Services (General)	Private Practitioners	*Medical Doctor *Registered Nurse *Licensed Prof. Nurse *Psychologist *Occupational Therapist *Physical Therapist *Dentists *Hearing Aid Dispenser *Nursing Home Adminr.	St. Bd. of Med. Examiners (lic) St. Bd. of Nursing (lic) St. Bd. of Nursing (lic) St. Bd. of Psychology (lic) Natl. Bd. of O.T. (cert.) St. Bd. of P.T. (lic) St. Bd. of Dentists (lic) St. Bd. of H.A.D. (lic) St. Bd. of N.H.A. (lic)
Special Education Programs	Local School Districts  School for Deaf- Blind	*Special Educ. Teacher *Psychologist *Speech Therapist *Audiologist *Speech Technicians *Occupational Therapist *Special Educ. Teacher	St. Bd. of Education (cert. with Spec.Ed.Endorsement) St. Bd. of Psychology (lic) St. Bd. of S.T & A. (lic) St. Bd. of S.T.& A. (lic) St. Bd. of Education (cert.) Natl. Bd. of O.T. (cert.) St. Bd. of Education (cert. with Spec. Ed. Endorsement) plus cert. by Council on Education of the Deaf)
Foster Care	Private Practitioners	*Foster Care Home	SRS
Social Services and Casemanagement for DD	State and Local	Social Worker	Natl. Assn. S.W. (cert.)
Day Care/MR	Private Non-Profit	DDCPT	SRS
Family Services/MR	Private Non-Profit	DDCPT	SRS

## TRAINING FOR DD PERSONNEL

The State of Montana has two major training components which are specific to professionals and paraprofessionals who work within the DD service system in the state:

The Technical Assistance Section of the Developmental Disabilities Division of SRS provides training support to direct service providers within Montana's community-based DD program. The Technical Assistance Section (TAS) has two major components: Regional Clinical Training and the Training Resource and Information Center.

**Regional Clinical Training:** There are currently nine Regional Clinical Trainers (RCTs) assigned throughout the State's five regions. RCTs plan, develop, implement, coordinate and evaluate training which relates directly to the services provided to DD clients. All training occurs on-site, in each group home and day program, to maximize applicability and generalization of training for staff in every different setting.

**Training Resource and Information Center (TRIC):** TRIC is primarily a materials and equipment library which exists to support RCT training activities, as well as the informational needs of DDD staff and providers. In addition to maintaining an active lending library of books, materials, films, tapes and audio-visual equipment, TRIC also develops new training materials when suitable information is not commercially available. TRIC also has a research capability with access to the Montana State Library's On-Line Reference computer. It is also a clearinghouse for training information developed by individual providers and agencies throughout the state.

The Mental Health Manpower Project, located within the Mental Health and Residential Services Division of the Department of Institutions, sponsors, plans and/or coordinates training for professionals who work within Montana's mental health system. In the past year, the following workshops and seminars have taken place:

- two workshops on aging and mental health problems of the elderly
- a conference on mental health and the law
- training in cardiopulmonary resuscitation at several state institutions
- a seminar on cognitive-behavioral approaches to depression
- a seminar on sex therapy
- a seminar on current trends in psychotherapy.

The conference on mental health and the law was a collaborative effort under the sponsorship of the Community Support Project (CSP),

which is within the same departmental Division, the Montana Supreme Court and the University of Montana. This workshop provided an opportunity for judges, lawyers and mental health professionals to discuss such issues as: commitment laws, the insanity defense, court-ordered treatment, and the role of the mental health professional in the legal process.

Other collaborative efforts between the Manpower Project and the CSP will include:

- developing a chronic mental illness component for the training of Native American paraprofessionals
- forming a subcommittee of the Montana Mental Health Association on consumer advocacy for a statewide partial hospitalization conference
- developing an "externship" program for clinical psychology students in rural Montana
- replicating an existing regional training program for volunteer case managers throughout the state.

The Manpower Project's recent accomplishments in the area of training include the following:

- negotiation of a contract with the University of Montana to place three pre-doctoral students in a rural and highly impacted population area in the Eastern Montana Community Mental Health Center
- development of inservice training on gerontology, law, and CPR for over 350 people in Montana
- implementation of one major activity which resulted in paraprofessionals providing services to minority populations.

Two projects currently underway will have a bearing on training for DD personnel:

- all public-sector mental health professionals are being asked to complete a training needs assessment. This survey is designed to identify training needs which are particularly relevant to improving services to priority service groups (Indians, the elderly, the chronically mentally ill, children and rural populations)
- in cooperation with the CSP, co-sponsoring a training conference on day treatment (day treatment programs serve primarily the chronically mentally ill).

Other general goals pertaining to training activities within the Mental Health and Residential Services Division include the following:

- development and sponsorship with the Office of Public Instruction a teacher's workshop on recognizing early signs of emotional disturbance in school children



- creation of a staff development plan for the community mental health centers and each mental health institution in the state
- planning, development and implementation of a recommended professional persons' certification law which will provide the framework for licensure of mental health professionals in Montana
- influencing the development of increased paraprofessional utilization and training.

The Personnel Preparation Division of the Montana University Affiliated Program Satellite is, with the assistance of the Montana University System, developing both Master's Degree and Undergraduate programs for DD professionals. The major emphasis of the Graduate Program for Human Development will be on Applied Behavior Analysis and will feature interdisciplinary skills development. This program is being developed in cooperation with the University of Montana (Missoula) Psychology Department.



## IN-SERVICE TRAINING ACTIVITIES

Rehabilitative Services Division, SRS: During 1979, the emphasis continued to be the training of the RSD staff on current advancements in the rehabilitation of the severely disabled. All training efforts were coordinated with regional training resources and, whenever possible, with Montana rehabilitation facility personnel. Two interagency training sessions were conducted with the Montana Employment Service and the Worker's Compensation Division.

The University of Northern Colorado (UNC) is the recipient of a Rehabilitation Services Administration Grant that is funding a Rehabilitation Facility Administration Training Program. This in-service stipend program is conducted partly "inhouse" at facility sites and partly on the UNC campus throughout Region VIII for facility managers and potential managers of sheltered workshops and work activity centers. 350 stipends are available annually and are advertised throughout Region VIII. The program has two major functions:

1. to offer continuing education courses in rehab facility administration to Region VIII facility (rehab & DD) personnel which may be taken individually or as part of an extended certificate program of courses.
2. to offer an experience-based Master of Science Degree in Business Administration with a focus on Rehab Administration.

The Chief of the Rehabilitative Services Bureau, the training officer and District Supervisor will use a coordinated approach to all training activities in 1980.

Two sessions a year are planned for 1980 for in-service orientation training on a regional basis in coordination with the University of Northern Colorado, RRCEP. Fifteen to 20 counselors and counselor aides will attend this two-week orientation on all aspects of rehabilitation, with a heavy emphasis on medical aspects and disabilities. There will also be two sessions for experienced counselors, the same type of training, but at a higher level. All new RSD staff receive SRS and vocational rehabilitation orientation.

Approximately one-third of the counselors will attend workshops on specific disabilities at the University of Colorado Medical Center in Denver. The University of Oklahoma will provide training in supervision for some of the supervisors. Staff development will be intensifying training for all classes of employees to comply with the requirements of 1973 and 1974 federal legislation. There will be increased emphasis on case-load management and case documentation.

Objectives for the future which concern staff training include:

- continuing to provide to Rehabilitation Counselors in-service training which emphasizes the availability of benefits from other programs in order to increase the amount of first resource use from other programs, thereby reducing unwarranted use of vocational rehabilitation funds.
- continuing to provide in-service training of staff in order to eliminate gaps in service programs, thereby providing prompt, complete and overall comprehensive services to clients.

Special Education Unit, OPI: The Montana Comprehensive System of Personnel Development(CSPD) is a broad-based effort involving the assessment of manpower and training needs of local programs and state operated programs delivering special education and related services to handicapped children and youth. The results of needs assessment activities carried out by all agencies and programs involved in the system are shared across agencies and programs to plan and carry out preservice and inservice training activities.

This cooperative endeavor involves the Office of Public Instruction, institutions of higher education, local school districts, state operated programs, community-based service providers, professional organizations and parent organizations.

The implementation of a CSPD involves bringing together numerous programs and personnel with the recognition that individual components of the system represent different levels of development. A series of cooperative activities has been implemented within the state which provide a structure and format for greater input and direct involvement of interested persons in inservice training, preservice training and dissemination activities.

A statewide survey of inservice training needs of personnel working with handicapped children and youth was conducted during December, 1979. A survey form was prepared and distributed to local school districts, special education cooperatives and state operated programs to determine the number of personnel needing training in 10 specified content areas. The 10 areas of training included in the survey were:

- individualized education programs
- nondiscriminatory testing
- utilization of materials in IEPs
- informal evaluations

- vocational education modifications
- least restrictive environment
- due process
- record keeping
- federal and state laws
- use of surrogate parents

The survey results showed that many special education personnel throughout the state want and need the types of training indicated above. Additional areas of training were requested from individual school districts in the areas of:

- budgeting for special education programs
- grading procedures
- storage of records
- grant writing
- characteristics of handicapping conditions
- classroom management.

The personnel to be trained in the areas listed include:

- regular education teachers
- special education teachers
- administrators
- psychologists
- physical educators
- guidance counselors
- speech therapists/audiologists
- vocational educators
- supervisors
- teacher aides
- parents/surrogates
- volunteers

The planning and delivery of in-service training to personnel working with handicapped children and youth is currently being carried out through the cooperative efforts of the Office of Public Instruction, local school districts, special education cooperatives, units of Montana higher education, Montana University Affiliated DD Program, Department of Institutions, Department of Justice, Department of Social and Rehabilitation Services, Department of Health and Environmental Sciences, and other public and private organizations.

The coordination of training resources to address the identified training needs is currently underway at both the state and local levels. The results of the above mentioned survey will be used to further these efforts.



Boulder River School & Hospital, Department of Institutions:  
The following seven programs are offered to the employees of the institution:

Pre-service training: a two-week, 75-hour induction training course for direct care employees. It includes: orientation, which all new employees attend; first aid, sanctioned by Red Cross, again all new employees attend; nursing procedures; behavior management; communications; institutional communications; gentle self-defense; and other areas of importance.

The Boulder Training Center: a one-week, 35-hour course on the methods and theory of the Boulder Training Model. Satisfactory completion of this course comprises half of the training requirement for an entry level direct care staff member to meet Habilitation Aide II qualifications.

Advanced health care: a seven-day, 28-hour course which makes up the second half of Habilitation Aide II training.

First line management training: a five-day, 20-hour course which provides the training background necessary to qualify for the shift supervisor (Habilitation Aide III) position.

Advanced management training: made up of a series of presentations and workshops for middle and upper level management personnel.

Western Montana College: an Associate of Science degree in Human Services through classes held at Boulder River School & Hospital, which are administered by Staff Development.

Continuing Education: programs are designed and presented or contracted by Staff Development to meet the special needs of different departments of the institution.

Eastmont Training Center, Department of Institutions:  
Training available to the Developmental and Habilitation Services staffs include:

- several training films have been viewed by both staffs
- periodic guest lectures, e.g., Philip Pallister, M.D., Shodair Children's Hospital
- "Adaptive Equipment" by Lorin Wright, P.T.
- "Developing Voluntary Motion" by Joy Hettinger, O.T.

- "Boulder Training Center Workshop", attended by BMT and Recreation Specialists
- Marc Gold Training Films - "Feedback", "Reinforcement", "Try Another Way"
- Use of Hoyer Lift
- "Sensory Training" by Joy Hettinger, O.T.
- "HandiVoice Demonstration" by Lorin Wright, P.T.
- Montana Symposium on Early Education and the Exceptional Child, Billings - attended by teacher, teacher aide and recreation aide
- Autism Workshop, Billings - attended by teachers, BMT, Recreation Therapist
- Use of Recreation Leisure Time
- Training session on feeding - attended by Dietary Staff.

Medically-related training included:

- Use of oxygen - attended by new employees
- Orientation to sterilizer
- Aseptic techniques - attended by Habilitation Aides
- Poison injection - in-service at hospital
- Seizures and administration of oxygen - attended by van drivers
- Orientation for new R.N.

Maternal & Child Health Bureau, SDHES: In-service training is offered to professionals and paraprofessionals who work in three programs which are under the administration of the SDHES:

- W.I.C.
- Child Nutrition Program
- Family Planning Programs

Social Services Bureau, SRS: In-service training is provided to personnel who provide the services offered by the social services program.





TABLE 6.2

## TRAINING FOR DD PROFESSIONALS

Federally Assisted Programs and State Agencies Responsible	Agency Providing Training	Training for Professionals Incorporating DD Content?		Training for Paraprofessionals Incorporating DD Content?	
		Yes	No	Yes	No
Education for the Handicapped (OPI)	1. OPI	X		X	
	2. Montana University System	X		X	
	3. School for Deaf/Blind	X			
	4. Montana UAPS	X			
Vocational Rehabilitation (SRS)	1. SRS	X		X	
	2. Univ. of Northern Colorado	X		X	
Public Assistance (SRS)	N/A		N/A		N/A
Medical Assistance (SRS)	SRS		X		X
Social Services (SRS)	SRS	X			X
Maternal and Child Health (SDHES)	SDHES	X		X	
Crippled Children (SDHES)	SDHES		X		X

TABLE 6.2 (Cont'd)

Federally Assisted Programs and State Agencies Responsible	Agency Providing Training	Training for Professionals Incorporating DD Content?		Training for Paraprofessionals Incorporating DD Content?	
		Yes	No	Yes	No
Comprehensive Health (MHSA) *	N/A	N/A		N/A	
Aging Services (SRS)	1. SRS		X		X
	2. Montana State University		B E I N G		D E V E L O P E D
Mental Retardation (SRS)	SRS		X		X
Mental Health and Institutionalized Mentally Retarded (Dept./Institutions)	1. Mental Health Manpower Project (Department of Institutions)	X		X	
	2. Community Support Project (Dept. of Institutions)	X		X	
	3. Boulder River Sch. & Hosp.	X		X	
	4. Western Montana College	X		X	X
	5. Eastmont Training Ctr.	X		X	

\*Planning Agency Only

## EVALUATION SYSTEM PLAN

As can be seen in Section 8 of this plan, the State of Montana repeats its assurance that it will submit to the federal government by October 1, 1980, a plan for a comprehensive system of evaluating services provided under Public Law 95-602.

The evaluation system plan will provide:

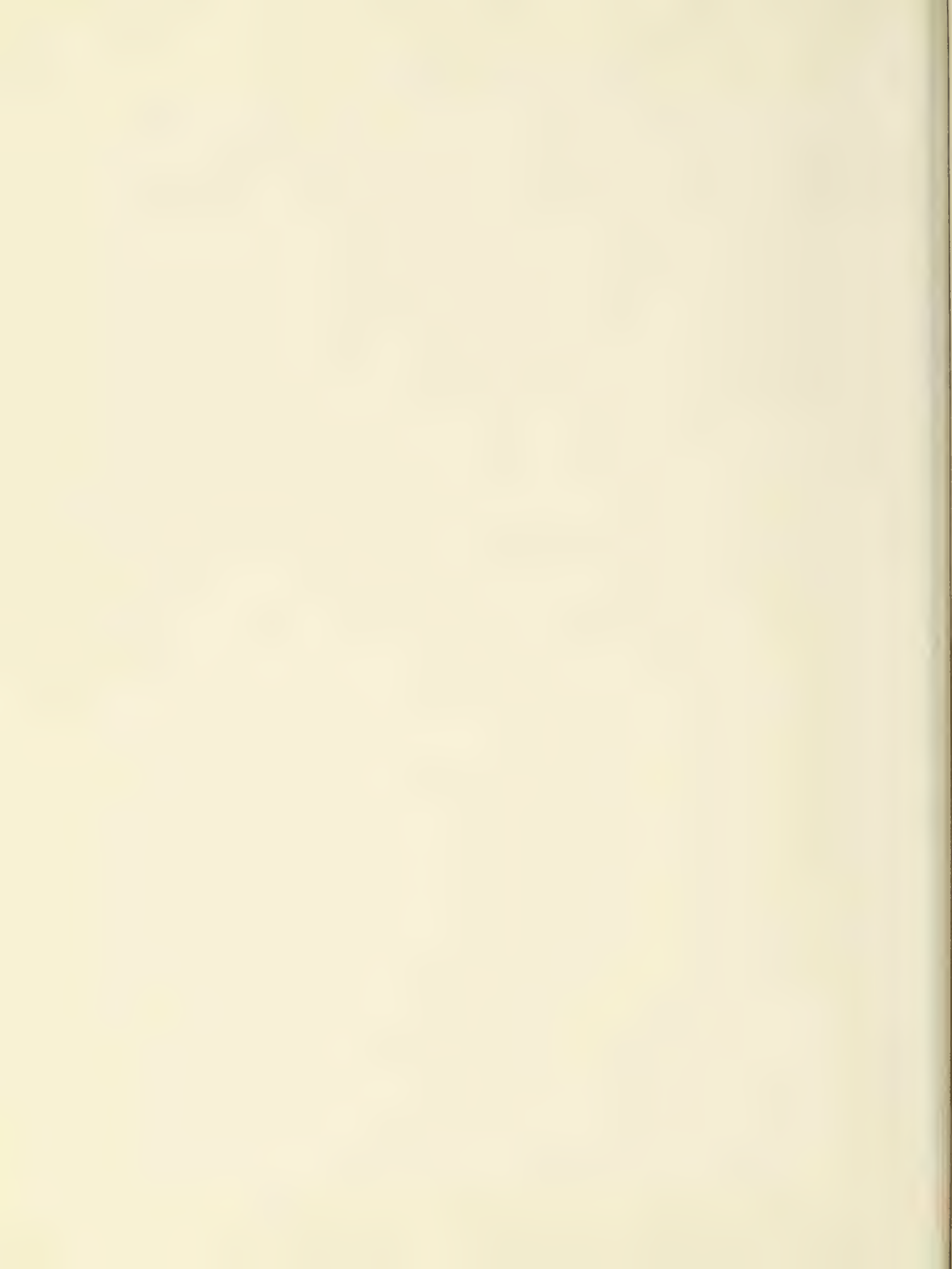
1. objective measures of the developmental progress of persons with developmental disabilities using data obtained from individualized habilitation plans;
2. a method of evaluating programs providing services for persons with DD which uses the measures referred to in paragraph 1;
3. cost estimates for development and implementation of the system; and
4. effective measures to protect the confidentiality of records of, and information describing, persons with developmental disabilities.





SECTION 7

SPECIAL PROGRAMS



## MONTANA'S POVERTY AREAS

The Table and the map on the following pages show the number of persons who reside within poverty areas in the state according to the U.S. Department of Health and Human Services (Health Resources Administration list of urban and rural poverty areas based on the 1970 Census). The Table also indicates that, in most cases, the poverty population represents only a very small portion of the total county population, e.g., the poverty population is never more than 23% of the total county population.

Since grants awarded by the State Council (from monies allocated under P.L. 95-602) fund projects which are statewide, regionwide, countywide or, at the least, citywide in scope, and the poverty areas identified by HHS comprise only small portions of total county populations, it is impossible to specify which of those projects serve persons who reside within those poverty areas. However, all projects funded during FFY 79 with the Council's P.L. 95-602 allocation, which are listed in Section 1, Table 1.3, were available to persons who reside within the identified poverty areas, even though it is not possible to specify precisely how many of those persons were actually served in each project.

Because of this overlap between poverty and non-poverty areas by projects funded with P.L. 95-602 monies and the accompanying difficulty in determining the number of persons who reside in poverty areas who would or could be served by those projects, the Council has made it a practice to request a 25% match from all Council grantees, rather than requesting a 10% match and then specifying that the grantee serve only the poverty population in his region or county. The poverty population in Montana is simply too dispersed to impose this sort of requirement on Council grantees.

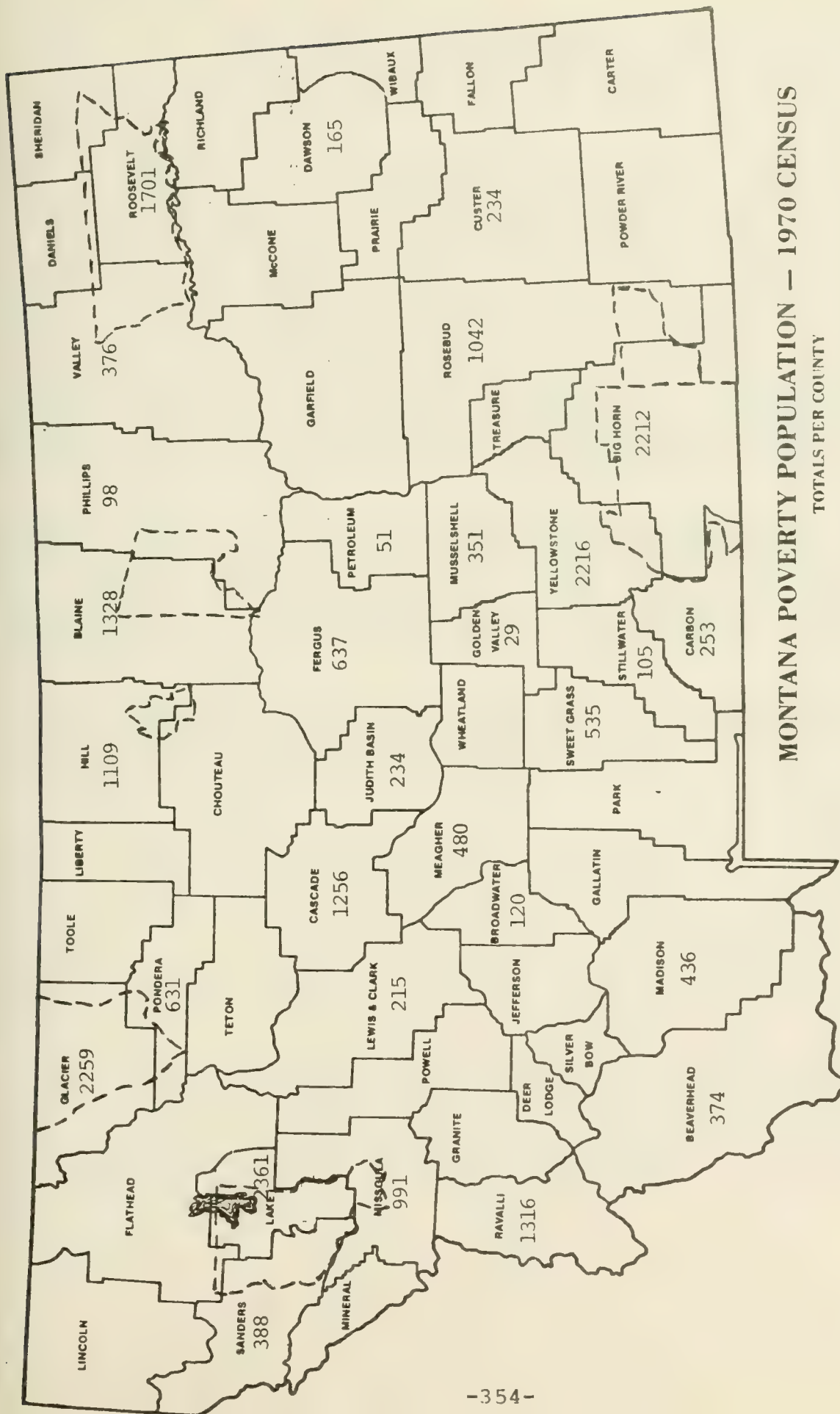
Technical and financial assistance provided both by Montana's DD-serving agencies and the Council are available to Montana's poverty areas in the same manner they are available to all other areas of the state.

The above discussion reflects attempts to serve Montana's poverty population with P.L. 95-602 funds. What follows is some discussion of what state programs funded with other sources of monies are doing to target their services on the state's low income and/or poverty population.

The eight-year-old gubernatorial Executive Order requiring state agencies to regionalize their services indicates an awareness that a widely-dispersed population such as Montana's needs a less centralized service system. Both the community-based DD system and the community mental health system have regional service delivery systems as do most other agencies which provide services to Montana's developmentally disabled population.

MONTANA POVERTY AREAS  
 ACCORDING TO HEALTH RESOURCES ADMINISTRATION, U.S.D.H.H.S.

<u>County</u>	<u>1970 Population</u>	<u># of Poverty Persons</u>	<u>% of Poverty Persons</u>
Beaverhead	8,187	374	.046
Big Horn	10,057	2,212	.220
Blaine	6,727	1,328	.197
Broadwater	2,526	120	.048
Carbon	7,080	253	.036
Cascade	81,804	1,256	.015
Custer	12,174	234	.019
Dawson	11,269	165	.015
Fergus	12,611	637	.051
Glacier	10,783	2,259	.209
Golden Valley	931	29	.031
Hill	17,358	1,109	.064
Judith Basin	2,667	234	.088
Lake	14,445	2,361	.163
Lewis & Clark	33,281	215	.006
Madison	4,014	436	.109
Meagher	2,122	480	.226
Missoula	58,263	991	.017
Musselshell	3,734	351	.094
Petroleum	675	51	.076
Phillips	5,386	98	.018
Pondera	6,611	631	.095
Ravalli	14,409	1,316	.091
Roosevelt	10,365	1,701	.164
Rosebud	6,032	1,042	.173
Sanders	7,093	388	.055
Stillwater	4,632	105	.023
Sweet Grass	2,980	535	.180
Valley	11,471	376	.033
Yellowstone	87,367	2,216	.025
Totals:	457,054	23,503	.051



## MONTANA POVERTY POPULATION — 1970 CENSUS

TOTALS PER COUNTY

Source: Health Resources Administration,  
U.S. Department of Health and  
Human Services

--- -- Boundaries of Montana Indian Reservations



Specific activities of the programs represented in this plan to assist Montana's poverty population are as follows:

Social Services Bureau: All services provided by the SSB are primarily geared toward the low income population, and particularly AFDC and SSI recipients.

Rehabilitative Services Division: See section on Minorities.

Maternal & Child Health Bureau: Provides technical assistance to poverty areas on request. All MCH programs have income eligibility criteria.

Public Assistance (Economic Assistance Division): See section on Minorities.

Aging Services: The Older Americans Act, which provides the mandate for this program, requires that all citizens over 60 years of age be served, but that those individuals with the greatest economic and social needs be given particular attention.

The map on the preceding page, showing Montana's poverty areas, indicates that much of the total poverty population in the state is located on or near the Indian reservations. Aside from two of Montana's "urban" counties, Cascade and Yellowstone, which contain the two largest cities in Montana, the largest concentrations of poverty persons in the state are in counties which contain Indian reservations: Big Horn, Rosebud, Roosevelt, Blaine, Hill, Glacier, and Lake.

For this reason, it is difficult to discuss poverty in Montana without discussing also the special needs of, and activities to make services available to, Montana's Native American population. The following portion of Section 7 contains a discussion of these needs and activities.

## MONTANA'S INDIAN CITIZENS

### On the Reservations

In Montana, the Indian Health Service (IHS) provides comprehensive health services to approximately 30,000 Indian people living on or near the seven reservations located in isolated rural areas in the State. Except on the Flathead Reservation, the services include extensive outpatient care and community outreach provided by IHS employees. The services include medical, nursing, mental health, social services, community health nursing, and health education. Nutrition services are limited. At Browning, Crow Agency and Harlem, IHS provides small community hospitals for the Indian people. At Poplar, IHS physicians provide hospital care in the local community hospital. On the Flathead Reservation, all medical care is provided by private physicians with IHS paying the fee. (See Table on the next page for organization in Billings area IHS office).

For Indian children with handicapping conditions, IHS serves the same role as a family practitioner would, except ancillary services such as community health nursing and social services are available. Children requiring care such as orthopedics and neurology are referred to specialists in the major Montana cities. If there are other sources such as Crippled Children's services or Medicaid, for third-party payments of this care, those services are used in preference to IHS funds.

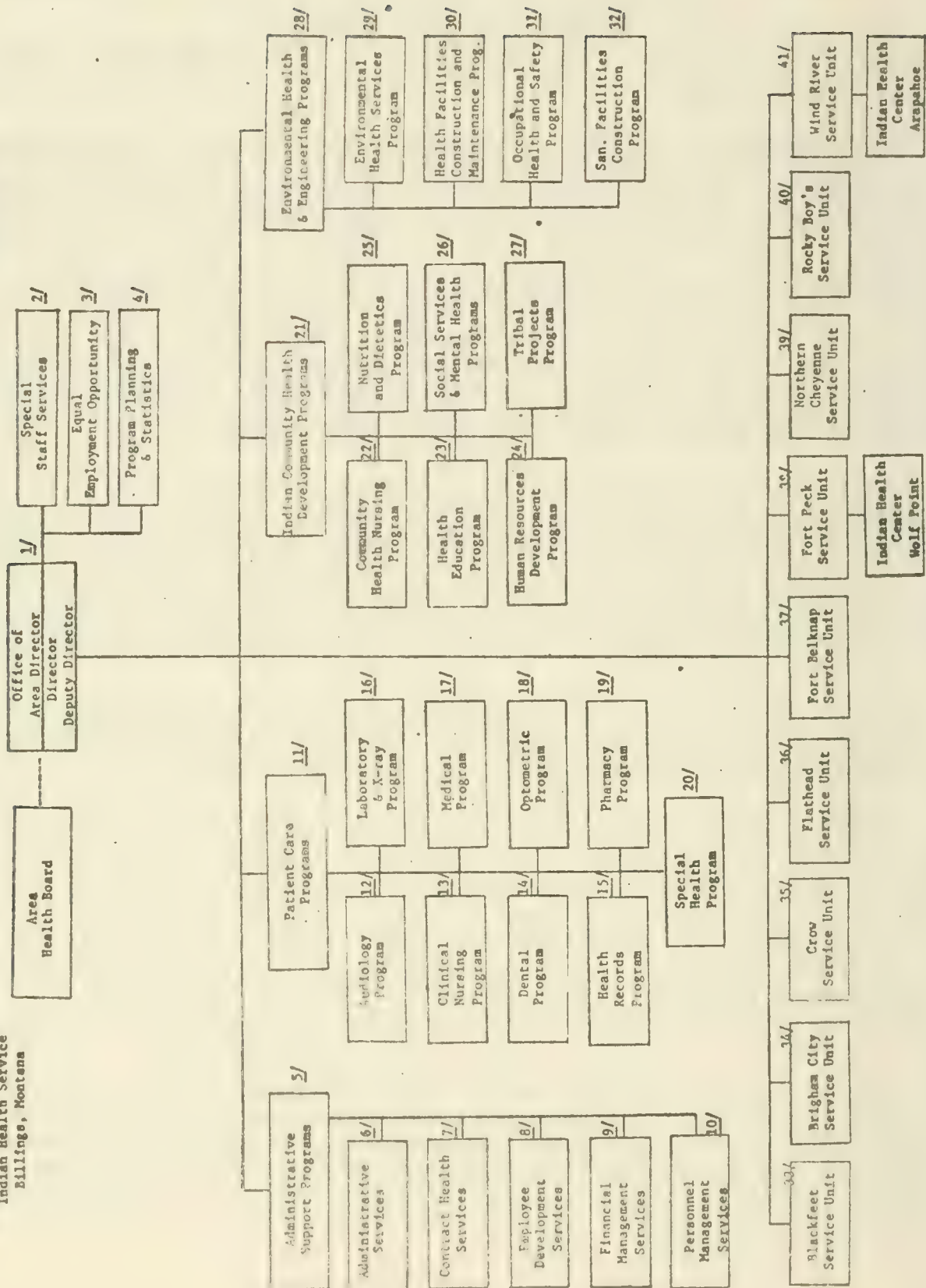
Although there is a move for IHS to provide clinics for Indian people in the urban areas, IHS essentially provides care only for handicapped Indian people living on the reservations.

These statements may not apply to all reservation communities, as the situations do vary, but, in general, there is no specific plan or program for children and adults with handicapping conditions. Given an individual with a handicapping condition, the responsibility falls upon the primary provider to pull together the appropriate resources to meet that individual's needs. Many resources may be called upon. Seldom is there an opportunity for these resources to function as a team because of the constraints of time and distance. Then the primary provider or community health nurse or the parent or other individual has the responsibility to coordinate the services.

The physicians, young people often not having completed even specialty training, are, by and large, untrained and inexperienced in providing care to persons with handicapping conditions. Good specialty care is now available in the larger cities in Montana, the only restrictions being distance, time, and money, with distance factors being the most critical.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
Public Health Service  
Health Services Administration  
Indian Health Service  
Billings, Montana

Billings Area  
Organization Chart





Community health nursing and social services are adequate. Mental health services in the reservation communities are geared to crisis intervention for adults and are not adequate for children's services in terms of staff time, training, and experience. Speech therapy and audiological services are available, though may be intermittent; the same situation exists for optometric services. Basic dentistry is readily available through IHS, and orthodontic care can usually be arranged if the condition presents a medical problem. Nutrition services are lacking in the reservation communities, although a one-time consultation can be arranged by the Area Office. The WIC program does provide general nutrition education, but cannot provide the skilled consultation needed by some handicapped persons.

Occasionally, a physical therapist living in the area might provide services, but physical therapy services are essentially lacking. Occupational therapy is totally lacking. Vocational counseling is provided by Vocational Rehabilitation on an itinerant basis. There is a lack of good psychological testing for pre-school Indian children.

In the past two years, IHS has established Developmental Assessment Clinics on a few of the reservations. The purpose of these clinics is to provide team assessment and planning for children with developmental problems. The teams are, as much as possible, composed of local people who might continue to have contact with the child. The clinic is well established on the Fort Peck Reservation. Clinics have now been conducted on the Northern Cheyenne, Fort Belknap and Rocky Boy's Reservations. It is the intent to continue these clinics at least on a quarterly basis. There are no immediate plans for similar clinics on the Flathead, Blackfeet, and Crow Reservations.

Other than the Developmental Assessment Clinics, IHS has no plans which specifically address unmet health needs of handicapped Indian people. IHS will, within the next year, be doing the EPSDT examinations for Indian children. This may help identify children with previously undetected health problems. Past experience with EPSDT leads the IHS to believe that any new problems uncovered will be minor ones.

There is no reliable data on the number of Indian persons with handicapping conditions. From time to time, one hears that Indian children have a higher prevalence of cleft palate or congenital hip dislocation, but IHS professionals cannot validate this claim. Fetal alcohol syndrome is of considerable concern in the reservation communities. Prospective studies are planned to identify the prevalence of drinking during pregnancy and fetal alcohol syndrome.

### Non-Reservation Indians

The Montana United Indian Association (MUIA), a coalition of organizations formed to, among other things, assist non-reservation Indians with various social and health problems, has established a health program which is intended to provide some limited services to handicapped Indians. Although the MUIA's funds for health services are significantly lower than those of the IHS, it is attempting to assist non-reservation Indians through its network of local organizations in eight Montana cities. In addition to its health program,

the MUIA has recently implemented, through the same network and under a federal grant, a mental health program for non-reservation Indians.

Although jurisdictional problems have hampered the development by state and local government agencies of many types of social and health programs on the Indian reservations, the drafters of the Montana state law authorizing the community-based DD system had the foresight to include a provision permitting reservation Indians in the state full access and entitlement to the programs within that system. This has enabled the Developmental Disabilities Division of SRS to establish and fund programs for DD adults on two of Montana's Indian reservations. Throughout the statewide system, in those two programs and in others located off the reservations, a total of 117 Native Americans were being served as of September, 1979.

Additionally, as a result of a State Council sponsored discussion which involved a joint discussion between Council members and representatives of some of Montana's Indian reservations at a Council meeting in 1979, two Tribal organizations have applied to the Council for funding for projects which are intended to identify DD persons on their respective reservations and to provide information and referral to needed services. These two grant applications are, at the present time, still being considered by the Council.

Since few people would disagree that DD services and birth defects prevention programs directed toward Montana's Indian populations are among the state's greatest needs, it is appropriate that special attention be given to these needs by both the State Council and the DD service system.

Following is a description of the activities of the state programs included in this plan in the area of serving Montana's Indian population:

Developmental Disabilities Division: As previously stated, programs for adult DD persons on two of Montana's Indian reservations (Blackfeet and Fort Belknap) have been established and funded by the Division.

Vocational Rehabilitation (Rehabilitative Services Division): The Division maintains an Affirmative Action Plan for hiring its Rehabilitation Counselors to insure the Counselors on the reservations include Indian staff.

Social Services Bureau: SSB staff have met and will continue to meet with all Tribal Councils regarding the Indian Child Welfare Act.

Maternal & Child Health Bureau: All programs offered by the Bureau are available to all Montana citizens, including the Indian population.

Public Assistance (Economic Assistance Division): This program maintains outreach coordinators on the Indian reservations in Montana.



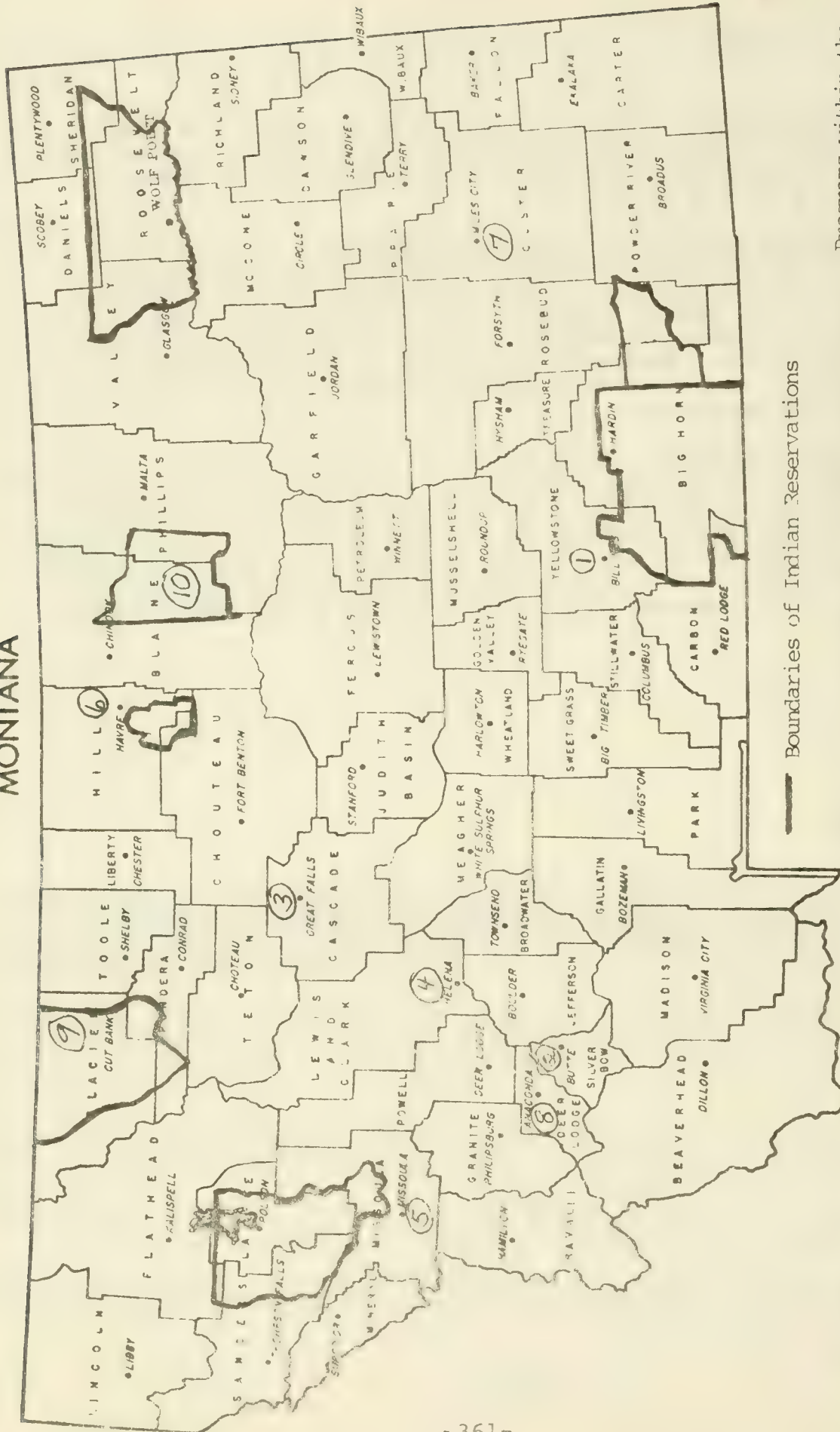
Aging Services Bureau: One entire substate region in the Aging Services network is composed of six of Montana's seven Indian reservations. This procedure gives special attention to the needs of Montana's aging Indian population.

Mental Health and Residential Services Division: Regions I and III mental health centers have contracts with reservations whereby Indian paraprofessionals are hired by the tribe to work fulltime on the reservation but obtain supervision and consultation from the center. Region V has a psychologist working almost fulltime on the Flathead Reservation. Region II, III, and IV offer services on an as-needed basis. Four Community Mental Health Centers have developed plans for Native Americans.

Visual Services Division: The Division maintains a policy of serving Indian clients on or off the reservation and will help those reservations which choose to maintain their own Rehabilitation Program to implement programs which will be, to the maximum extent feasible, comparable to rehabilitation services provided to other handicapped individuals in the state. The Division maintains nine counselors in the state which provide geographic coverage to all seven Indian reservations.

The maps on the following pages show the locations of 1) Montana's Indian reservations, 2) the two reservation programs which are a part of the statewide community-based DD system; 3) the organizations which comprise the Montana United Indian Association; and 4) the IHS facilities in Montana.

# MONTANA



— Boundaries of Indian Reservations

Programs within the DD community-based service system:

9. Blackfeet DD Program, Browning
10. Blaine County Activities, Harlem

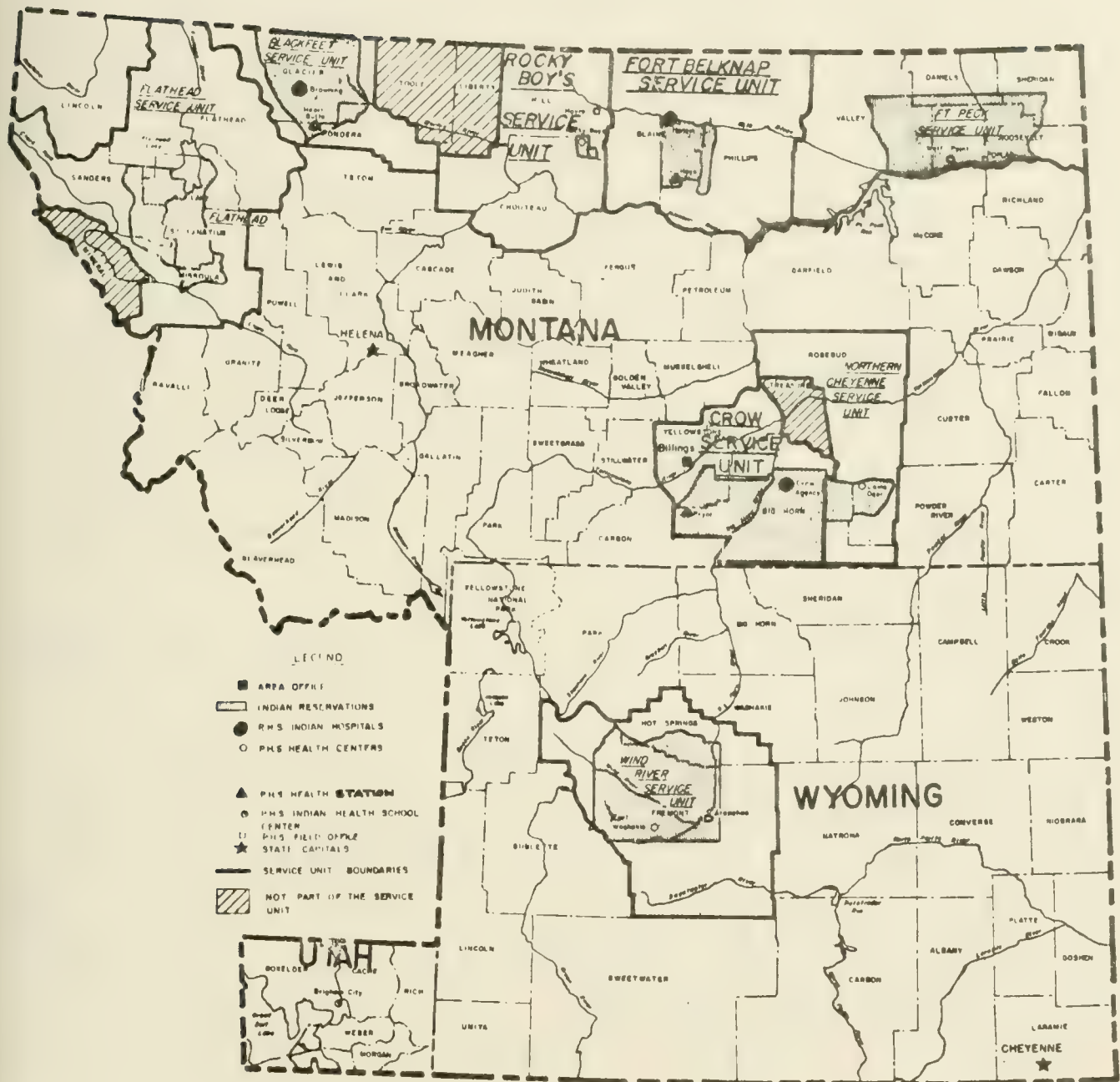
Member Organizations, Mt. United Indian Assn.:

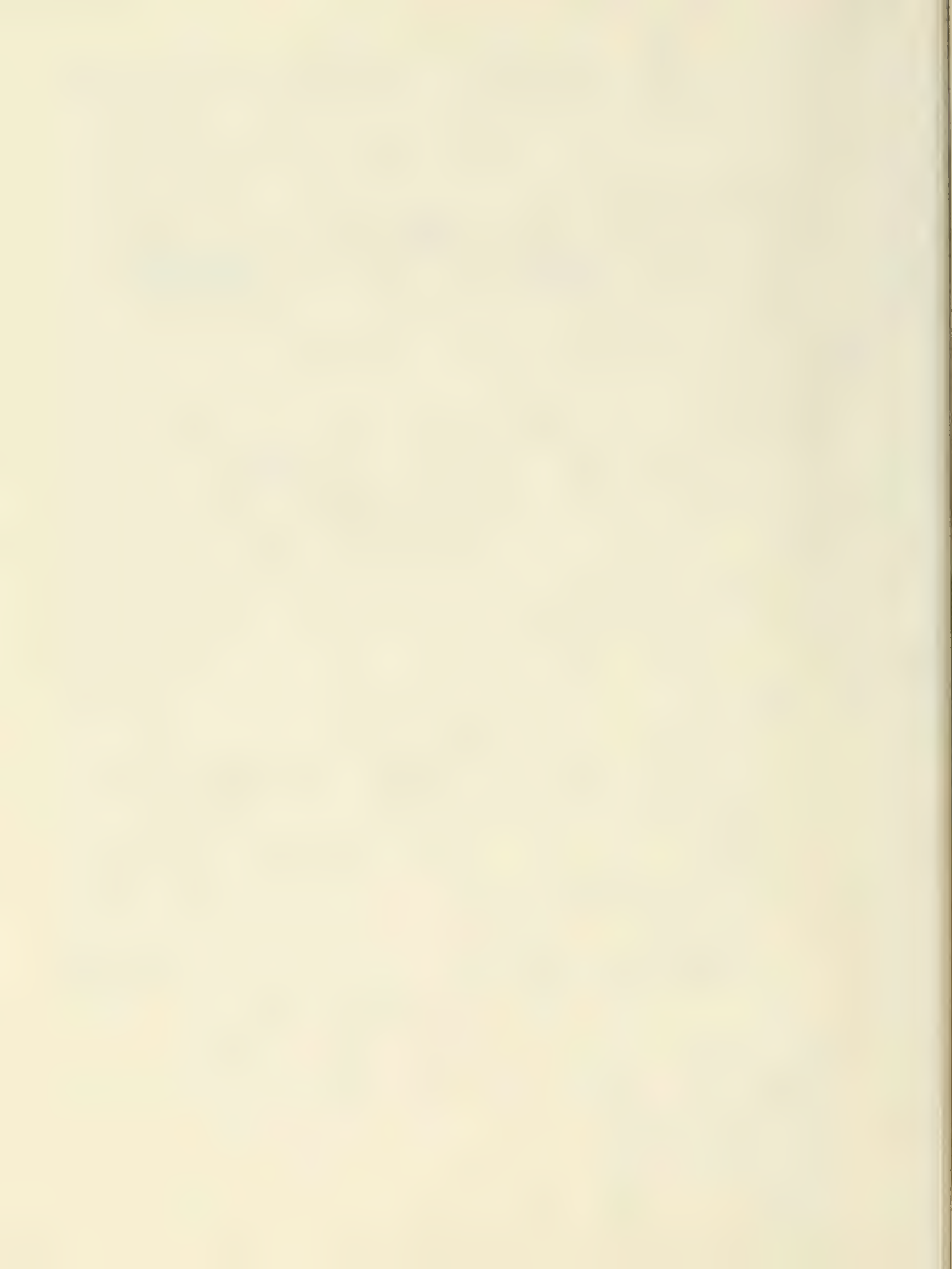
1. Billings American Indian Council
2. North American Indian Alliance (Butte)
3. Great Falls Indian Education Center
4. Helena Indian Alliance
5. Missoula Qua-qui Corporation
6. Hi-Line Indian Alliance (Havre)
7. Indian Development & Educ. Alliance (Miles City)
8. Anaconda Indian Alliance

STATE PUBLISHING COMPANY  
Helena

# BILLINGS AREA

## INDIAN HEALTH SERVICE







## VOLUNTEERS IN THE DD SYSTEM

Until December 31, 1978, the Montana State Department of Community Affairs contained a bureau whose function it was to investigate the extent to which (if at all) volunteers were being utilized by state agencies in the delivery of state-funded programs. Because of inadequate funding, the Volunteer Bureau was abolished on that date. However, the Bureau's report on its efforts contained the following comments:

"The Volunteer Bureau of the Human Resources Division/Department of Community Affairs serves as an advocate for voluntarism in Montana. Bureau staff members felt that since their agency was a state unit, they should take positive steps to make sure that state government was using volunteers to its fullest potential. In November of 1977, the Volunteer Bureau visited with the directors of 18 departments of state government to explain about the Bureau's function, and to inventory the use of volunteers within their departments. There were enough questionnaires distributed for every division within the departments to respond. Sixteen out of the eighteen departments responded to the survey. Data gathered from the survey indicated that 1,135 volunteers were used in 1977, with a cost benefit of \$99,411."

The report further commented that "The results were basically positive, but at the same time they showed little enthusiasm for expanded use (of volunteers)."

Past studies have indicated that one possible reason for the lack of enthusiasm by state agencies for utilizing volunteers in delivering services (social, health, or otherwise) is the absence of statutory authorization for such activities. Although Montana state laws do not prohibit the use of volunteers in providing state-funded services, they are not clear as to restrictions which might apply in such areas as worker's compensation, use of state (or other publicly-owned) vehicles, liability in the event of injury to a volunteer worker, etc., thus it is probable that programs such as "Foster Grandparents" and "VISTA" have established a policy of paying their volunteers a small stipend in order that their "volunteers" would have status as employees and the program would, therefore, have no need to be concerned about the vagueness of the law in connection with utilizing unpaid volunteers to provide services.

The Volunteer Bureau sponsored unsuccessful legislation during the 1977 Session of the Montana Legislature which would have given statutory authorization for the use of volunteers by state administered programs. The legislation, if enacted, would have clarified issues such as those addressed in the above paragraph. No similar legislative proposals were presented during the 1979 Session of the Legislature.



Despite the uncertainties indicated above, some state programs which serve DD persons currently utilize volunteers. Discussion of this follows:

Social Services Bureau:

The Volunteers to Youth program provides support for volunteer programs that provide a meaningful relationship with an adult for children from single parent families or those families where a significant "other person" is essential to a child's well-being. There are over 400 volunteers involved in this program. The Bureau also utilizes volunteers in connection with child abuse and neglect cases, i.e., as counselors for the "Parents Anonymous" organization.

Mental Health & Residential Services Division:

One of the 1981 goals of the statewide mental health system is "To promote volunteer program development throughout the State of Montana." An objective to accomplish this goal is "To sponsor a seminar for community mental health center and institution employees on the use of volunteers in service delivery."

Boulder River School and Hospital utilizes advocates, foster grandparents and other volunteers who serve as "Responsible Persons" for residents of the institution.

Developmental Disabilities Division:

The Division uses volunteers primarily within the regional council system, i.e., the members of the Regional Developmental Disabilities Councils in Montana are volunteers. The provider Agencies which contract with the Division to conduct the programs within the statewide community-based DD system use volunteers in varying numbers and manners.

Special Education Unit:

Various school districts utilize parents, grandparents, students and other interested individuals from the general public as volunteers.

Maternal & Child Health Bureau:

Both the Family Planning Program and the W.I.C. Nutritional Program utilize volunteers.

School for the Deaf and Blind:

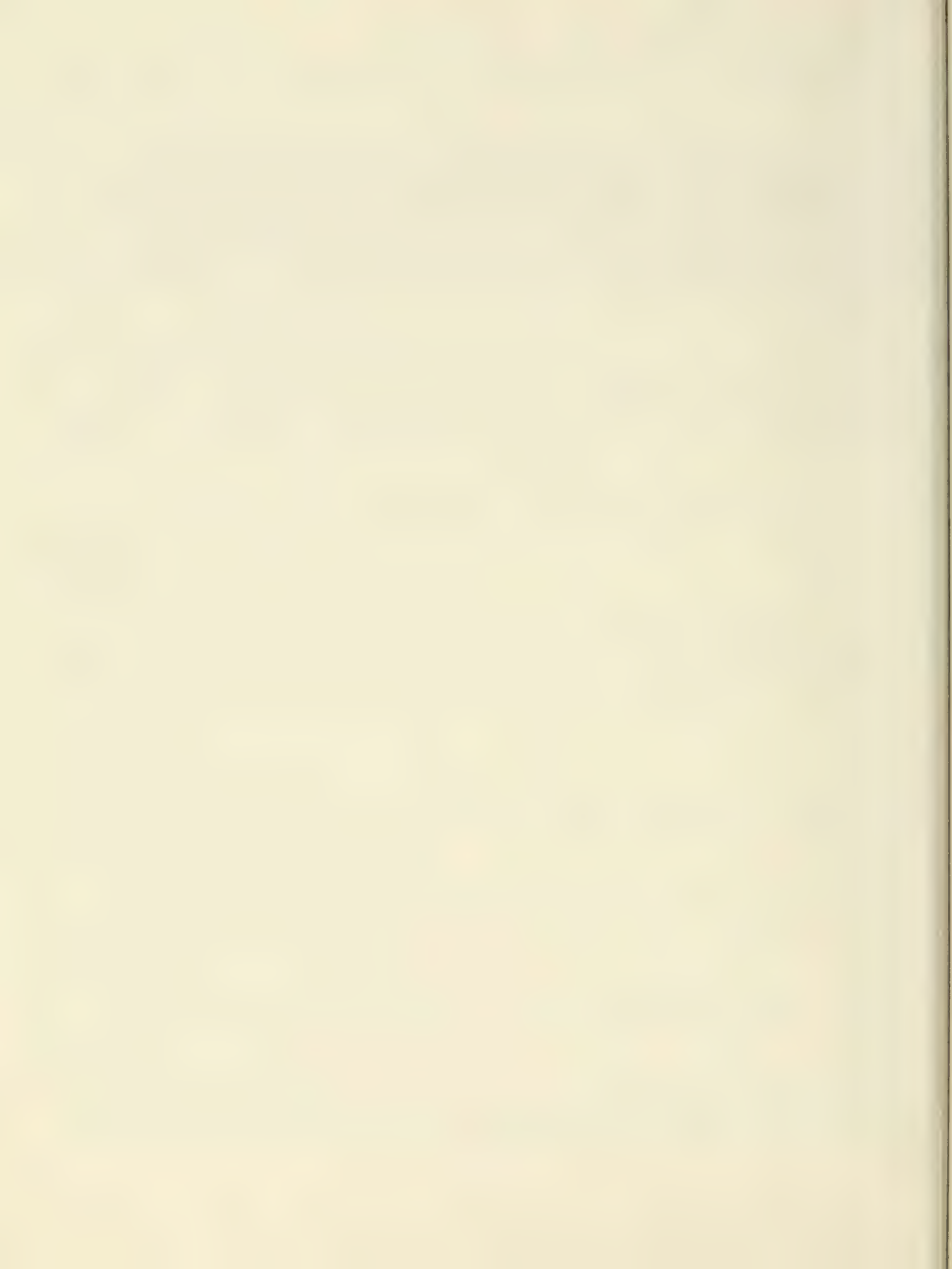
"Foster Grandparents" and college and high school students are utilized in volunteer programs.

Aging Services Bureau:

Volunteers are utilized to staff Senior Citizens' Centers and in the Nutrition and Information and Referral Programs.

State Council:

The State Council is composed itself primarily of volunteer members, as are the Regional DD Councils, and has assisted and/or cooperated with other volunteer organizations (consumer groups) in such projects as monitoring legislation of interest to the DD system, distributing informational brochures and materials, planning for and conducting workshops and conferences, and engaging in long-range planning for the Montana DD system. These activities will continue in the future. The Council also encourages its grantees to utilize volunteers in their projects.

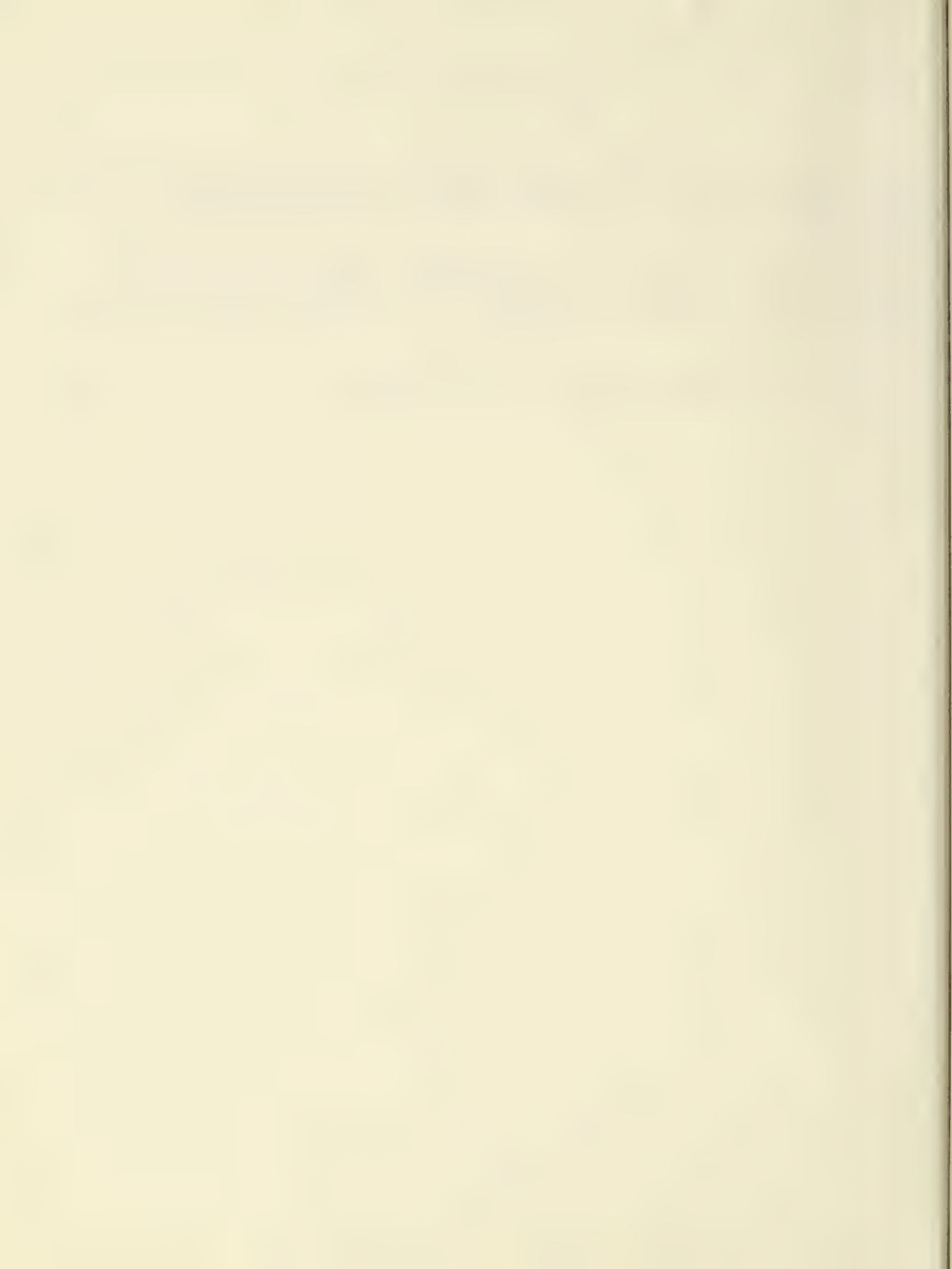


## EMPLOYEE PROTECTION PLAN

The State Plan must provide for fair and equitable arrangements to protect the interests of all employees affected by actions under the Plan to provide alternative community living arrangement services.

Since the Montana State Developmental Disabilities Plan for 1981-83 does not contain a proposal to initiate any alternative community living arrangement services, institutional employees will not be affected for the 1981 plan year.

If this situation changes in subsequent years, plans to develop an employee protection plan will be initiated.





## PUBLIC AWARENESS/OUTREACH

State and Regional DD Council members represent an unofficial, informal outreach program for the DD system in Montana. Council members are frequently contacted by persons who are either new to the state or have recently found themselves in need of DD services and are asked for information about what to do and who to talk to about the needed services. In a state with such a widely dispersed population the fact that virtually every county in the state is represented on either the state or regional councils is an important feature. This, in effect, means that there is a "contact person" in almost every county to provide this sort of "Information and Referral" service.

Council members are also, from time to time, asked to speak about the nature and purpose of various DD programs to local organizations and agencies which have no connection with the DD network. At least one of these council members speaks periodically to high school students on the subject of prevention of mental retardation and other birth defects.

Council members are also, from time to time, asked to speak on the subject of the nature and purpose of various DD programs and the concept of deinstitutionalization to local organizations and agencies which have no connection with the DD network.

The State Council staff has on-going duties in the area of distributing literature on such subjects as rights of handicapped persons, prevention of birth defects, how and where to access services, etc. Prior to each legislative session, the Council offers to new legislators information and materials explaining the existing DD system, the purpose of the various types of programs, the history of deinstitutionalization in Montana, and summaries of laws impacting the DD system which have passed in recent years.

The state programs' "outreach" activities are described below:

### Social Services Bureau:

Local county welfare offices maintain on-going outreach programs.

### Developmental Disabilities Division:

Division staff meet with public groups and concerned citizens as needed or requested. Providers who contract with the Division to conduct the programs locally have a variety of outreach programs.

### Rehabilitative Services Division:

The Division utilizes Counselor Aides for outreach programs in Billings and Great Falls. They also utilize newspaper ads to inform the public when Counselors will be in the local areas, and invite persons needing services to contact the Counselor.

### Special Education:

The "Child Find" project has utilized extensive radio, TV and newspaper ads and pamphlet handouts throughout the state.

### Maternal & Child Health Bureau:

The Bureau utilizes media advertising and pamphlet handouts for programs such as Family Planning, W.I.C. and special projects. Some mail contacts are made to inform of programs of interest to specific individuals.

### School for the Deaf and Blind:

Pamphlets and a handout information sheet are utilized to inform the public of services available at the School.

### Medical Assistance (Economic Assistance Division):

This program utilizes news releases and mailed information to professionals to inform of their services.

### Handicapped Children's Services:

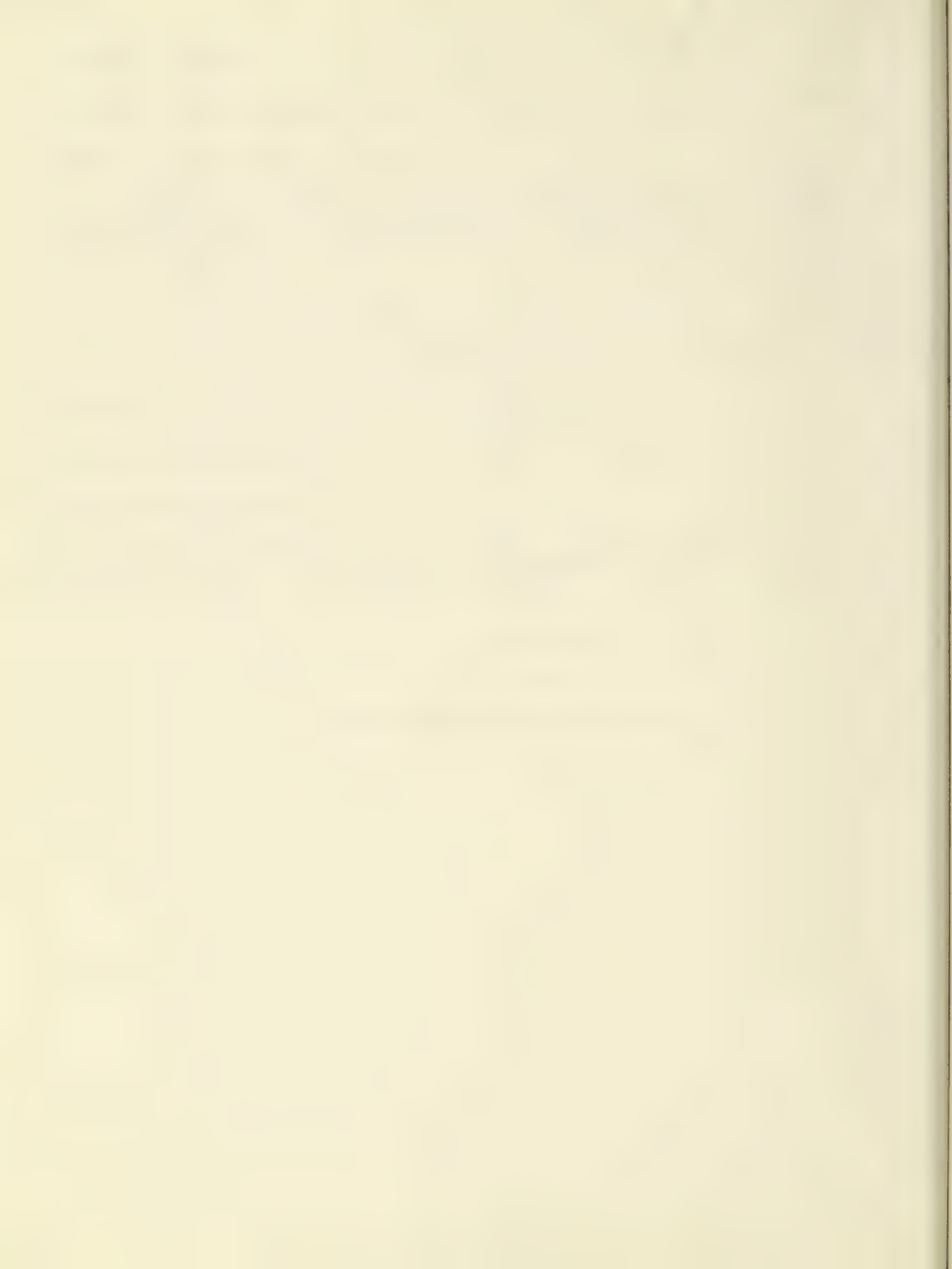
A brochure explaining the services has been developed and is being widely distributed. All new physicians in the state are informed by mail of the program's services.

SECTION 8

ASSURANCES

AND

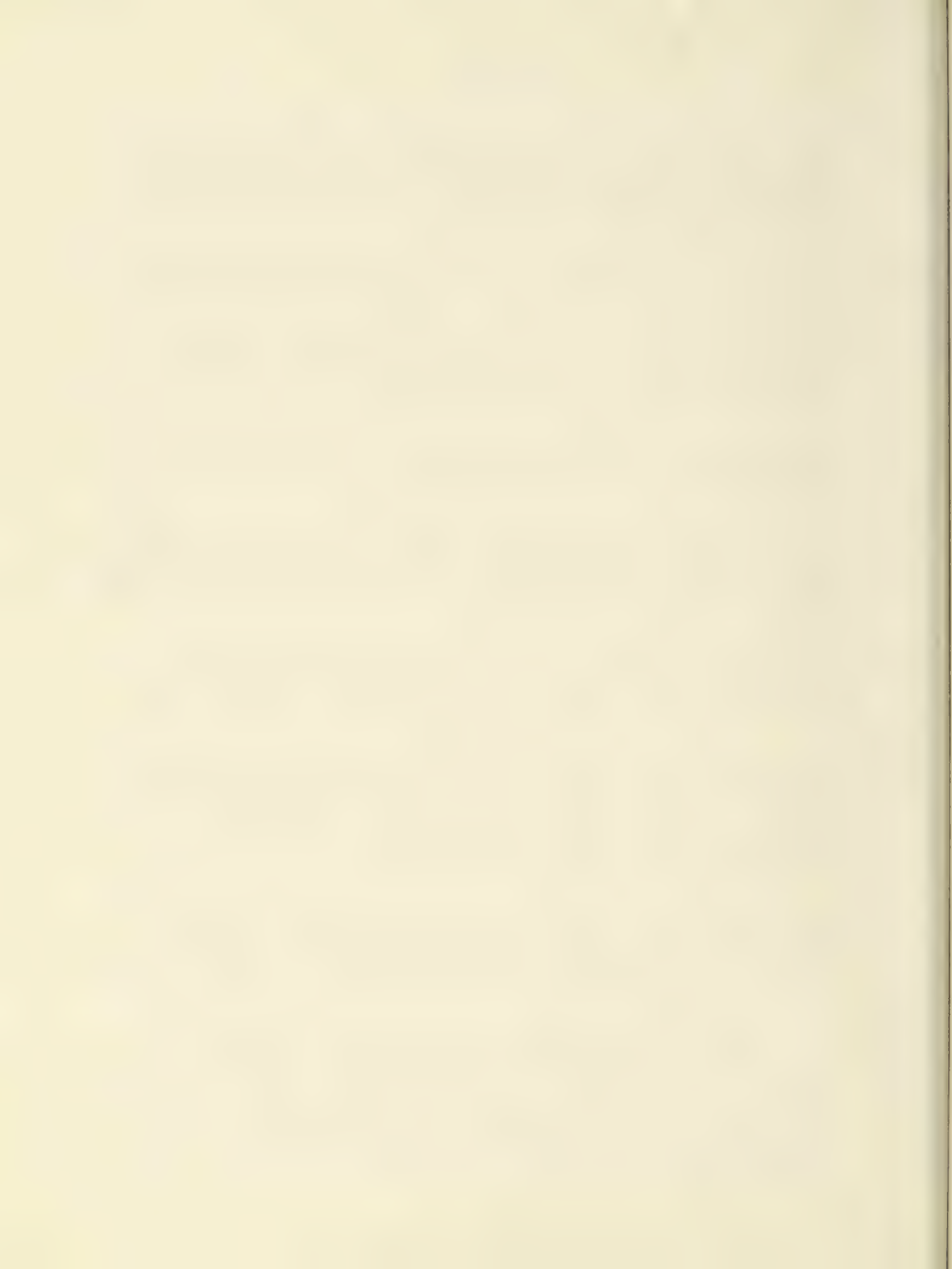
INDIVIDUAL HABILITATION PLANS



## ASSURANCES

1. In accordance with Section 133(b)3A, the State assures that funds paid to the State will be used to make a significant contribution toward strengthening services for persons with developmental disabilities through agencies in the various political subdivisions of the State.
2. In accordance with Section 133(b)3B, the State assures that part of the funds allotted under this Act to the State will be made available to public or non-profit private entities.
3. In accordance with Section 133(b)3C, the State assures that none of the Federal funds will be used to replace non-Federal funds presently used for services provided for individuals with developmental disabilities.
4. In accordance with Section 133(b)3D, the State assures that there will be reasonable State financial participation in the cost of carrying out the State Plan.
5. In accordance with Section 133(5)(A)(i), the State assures that services furnished, and the facilities in which they are furnished, under this plan for persons with developmental disabilities will be in accordance with standards prescribed by the Secretary in Regulations.
6. In accordance with Section 133(5)(A)(ii), the State assures that buildings used in connection with the delivery of services assisted under this plan will meet standards adopted pursuant to the Architectural Barriers Act of 1968.
7. In accordance with Section 133(5)(C), the State assures that the human rights of all persons with developmental disabilities (especially those persons without familial protection) who are receiving treatment, services, or habilitation under programs assisted under this title will be protected consistent with Section 111 (relating to rights of the developmentally disabled).
8. In accordance with Section 133(b)(1)(C), the Administrative Agency assures the Secretary of the Department of Health, Education and Welfare or her designee that the Agency will submit in a timely and complete manner all required program and fiscal reports.
9. In accordance with Section 110, the State assures that it will adopt not later than October 1, 1980, a comprehensive system for the evaluation of services assisted under this Act provided to persons with developmental disabilities and submit such plan to the Secretary no later than October 1, 1980. After HEW approval, the State further assures that it will implement the approved evaluation plan no later than October 1, 1982.





## INDIVIDUAL HABILITATION PLANS

In relation to services for developmentally disabled persons in Montana, individual program plans are utilized by nine programs. Those nine programs and the agencies which administer them are:

1. special education services (Special Education Unit, OPI)
2. vocational rehabilitation (Rehabilitative Services Division, SRS)
3. developmental disabilities services (DDD, SRS)
4. social services (Social Services Bureau, SRS)
5. institutional services for the mentally retarded (Boulder River School and Hospital, Department of Institutions)
6. institutional services for the mentally retarded (Eastmont Training Center, Department of Institutions)
7. institutional services for the mentally ill (Warm Springs State Hospital, Department of Institutions)
8. training for the deaf, blind and deaf/blind (School for the Deaf and Blind and Montana deaf/blind programs)
9. handicapped children's services (MCH/SDHES).

Montana State law requires the development and maintenance of individual program plans for special education students (20-7-402, M.C.A. 1979), institutionalized mentally retarded persons (53-20-148), institutionalized mentally ill persons (53-20-162), and for developmentally disabled individuals in community DD programs (53-20-203).

The following pages contain a sample copy of the IPPs for each of these programs and a checklist for each IPP summarizing its content.



INDIVIDUAL EDUCATIONAL PROGRAM

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

School \_\_\_\_\_ City: \_\_\_\_\_

Duration of I.E.P. \_\_\_\_\_ to \_\_\_\_\_ Date I.E.P. Written \_\_\_\_\_

Time In Special Class \_\_\_\_\_ Time in Regular Education \_\_\_\_\_

Specific Education and/or Support Services	Time to be provided	Projected Date of Initiation	Duration of Services

Annual Goal # \_\_\_\_: \_\_\_\_\_ Date Completed \_\_\_\_\_

Baseline: \_\_\_\_\_

Short Term Instructional Objectives (written in behavioral terms with  
criteria for evaluation of objectives and timeline for evaluation)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Annual Goal # \_\_\_\_: \_\_\_\_\_

Baseline: \_\_\_\_\_

Short Term Instructional Objectives (written in behavioral terms with  
criteria for evaluation of objectives and timeline for evaluation)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

(Attach additional annual goals and short term objectives as necessary)

Annual Goal # \_\_\_\_:

Date  
Completed

Baseline:

Short Term Instructional Objectives (written in behavioral terms with criteria for evaluation of objectives and timeline for evaluation)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Annual Goal # \_\_\_\_:

Baseline:

Short Term Instructional Objectives (written in behavioral terms with criteria for evaluation of objectives and timeline for evaluation)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Annual Goal # \_\_\_\_:

Baseline:

Short Term Instructional Objectives (written in behavioral terms with criteria for evaluation of objectives and timeline for evaluation)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

(Attach annual goals and short term objectives as necessary)



I.E.P. Developed by:

Signature

Role

Signature

Role

\_\_\_\_\_  
Administrator or Designee

\_\_\_\_\_  
Regular Education Teacher

\_\_\_\_\_  
Special Education Teacher

Sign the appropriate statement:

I have had the opportunity to participate in the development of this Individual Education Program and approve of its content and the educational placement/service for my son/daughter.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

I disagree with the Individual Education Program and do not agree to the educational placement.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

# CHECKLIST

FOR INDIVIDUAL Education PLAN OF  
Special Education Unit, Office of Public Instruction

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service?	(X)	( )
16. Does the plan specify the duration of each service?	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )

## INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM

Status: 10 thru 24

has met the eligibility criteria

(Last Name)

(First)

17/00010

or Vocational Rehabilitation Services. The following INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM was jointly developed on the basis of COUNSELING and the following information. The selected diagnostic services indicated below were utilized in the evaluation of this client for rehabilitative services and provide the basis for the development of this PROGRAM and for the determination of the vocational objective.

## CHECK THE APPROPRIATE BOXES:

- ☐ Diagnostic Surgery      ☐ Employment History      ☐ Extended Evaluation      ☐ General Physical Examination  
☐ Personal Adjustment Training      ☐ Psychological Evaluation      ☐ School Transcripts & other academic information  
☐ Social History      ☐ Specialist Medical Evaluation      ☐ Work Adjustment Training      ☐ Work Evaluation  
☐ Other (*specify*):

LONG-RANGE VOCATIONAL OBJECTIVES:

DOT CODE:

INTERMEDIATE OBJECTIVES FOR GOAL ATTAINMENT:

SPECIFIC VOCATIONAL REHABILITATIVE SERVICES TO BE PROVIDED IN ORDER  
TO ACHIEVE THE ESTABLISHED VOCATIONAL OBJECTIVE.

[illegible]

Basis for Evaluation of Applicant's Progress Toward Program Objective:

Client's Opinion of Rehabilitation Program:

#### SUMMARY STATEMENTS OF JOINT COMMITMENT

1. I understand that this program developed jointly by my counselor and me, is subject to change on the basis of changing circumstances and new information, and that it may be terminated, and that I may be declared to be ineligible on the basis of a finding that a reasonable likelihood of achieving a vocational goal no longer exists.
2. I understand that it is my responsibility to cooperate in carrying out the program and make reasonable efforts on my own behalf. This includes the keeping of appointments and attendance at scheduled activities. It is my responsibility to attain acceptable grades or ratings at training and other appropriate activities, and also to carry forth medical or other professional instructions. Failure to do so may result in ineligibility for further services to the extent that such failure tends to make employability unlikely.
3. I understand that services are predicated on availability of Federal and State Fundings.
4. I have identified and will commit all similar benefits towards the costs of this IWRP.
5. I understand that this program will be evaluated at least annually regarding progress toward the employability goal and in regard to necessary changes. There will be a written record of such reviews and evaluations.
6. I understand my right to be fully consulted regarding an amendment to the WRITTEN REHABILITATION PROGRAM.
7. I understand there is the possibility of an unavoidable delay in the implementation of my program.
8. I may discuss a problem or grievance with a rehabilitation counselor or coordinator at any time upon scheduling an appointment.
9. If dissatisfied with any action with regard to the furnishing or denial of Vocational Rehabilitation Services, I may file a request for an administrative review of the action to be made by a member or members of the supervisory staff of the Division.
10. If dissatisfied with the finding of the administrative review, I will be granted an opportunity for a fair hearing before the Department's Hearing Officer.
11. As a condition of any action to change status from eligible to ineligible for vocational rehabilitation, I will be given the opportunity for full consultation in such a decision.
12. Ineligibility decisions will be based upon factors which are recorded in the official record, and the decision will be certified by the appropriate Division staff member.
13. If determined ineligible, I will be given the opportunity to participate in annual review of that decision.
14. I understand my case will be closed from active service when the vocational objective is met and I have maintained employment for at least 60 days. I also understand that after my case is closed rehabilitated, there are Post-Employment Services available.
15. All information received by the agency is confidential and will only be released upon receipt of a signed release form.
16. If needed, I understand interpreter services will be provided. This includes language as well as deaf.
17. I have fully participated in the development of this PROGRAM, and I have received a copy of this document.

REHABILITATIVE SERVICES DIVISION WILL NOT DISCRIMINATE AS TO ACCEPTANCE DETERMINATION, SERVICES, OR EMPLOYMENT IN REGARD TO RACE, COLOR, CREED, SEX, AGE OR HANDICAP.

\_\_\_\_\_  
(Counselor Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Client Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Supervisor Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Client Representative or Witness Signature)



## INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM FOR EXTENDED EVALUATION SERVICES

has not met the eligibility criteria

(Last Name)

(First)

(Middle)

for Rehabilitation Services on the basis of the initial diagnostic evaluation. The existing diagnostic information has not adequately assessed this individual's handicap as it relates to employment and we are unable to determine this person's rehabilitation potential.

**The Diagnostic Service(s) Utilized in the Initial Evaluation Process were:**

- ☐ General Physical Exam.      ☐ Psychological Exam.      ☐ Specialist Medical Exam.      ☐ Vocational Testing
- ☐ Work Evaluation      ☐ Other: \_\_\_\_\_

This INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM for Extended Evaluation Services has been mutually agreed to and jointly planned for the purpose of obtaining more definitive clinical and vocational information deemed necessary in order to more clearly establish this Applicant's rehabilitation potential.

**Intermediate Rehabilitation Goal & Objectives:**

[illegible]



Basis for Evaluation of Applicant's Progress Toward Program Objective

Client's Opinion of Rehabilitation Program:

SUMMARY STATEMENTS OF JOINT COMMITMENT

1. I understand that a thorough assessment of my evaluation will occur as frequently as necessary, but will occur at least once every "90" days in order to evaluate progress during the Extended Evaluation process. This evaluation of progress will be accomplished as a "joint review" and a record of this evaluation shall be maintained as a part of my case file. Any change in this program will require a mutual agreement and joint planning by me and the RSD Counselor.
2. I understand that it is my responsibility to cooperate to carry out the program and make reasonable efforts on my own behalf. This includes the keeping of appointments and attendance at scheduled activities. It is my responsibility to attain acceptable grades or ratings at training and other appropriate activities, and also to carry forth medical or other professional instructions. Failure to do so may result in ineligibility for further services to the extent that such failure tends to make employability unlikely.
3. I have identified and will commit all similar benefits toward the costs of this IWRP.
4. I understand that if the Extended Evaluation process substantiates a lack of sufficient rehabilitation potential, I will be considered ineligible for further rehabilitation services at that time.
5. Ineligibility decisions will be based upon factors which are recorded in the official record, and the decision will be certified by the appropriate Division staff member. If determined ineligible, I will be given the opportunity to participate in annual review of that decision.
6. Either myself, guardian, or other representatives will be afforded the opportunity to express our views regarding status of ineligibility and our expressed views will be recorded as a Program Amendment to this PROGRAM.
7. I understand that services are predicated on availability of Federal and State fundings. I also understand there is the possibility of an unavoidable delay in the implementation of my program.
8. It is the mutual understanding of myself and the Division that the listing of the planned services does not imply a legal obligation by the Division to provide such services. The Division, within the limits of its capabilities and in accordance with the law and regulations, will implement this PROGRAM.
9. If needed, I understand the interpreter services will be provided. This includes language as well as deaf.
10. If dissatisfied with any action in regard to the furnishing or denial of Vocational Rehabilitation Services, I may file a request for an administrative review of the action, to be made by a member or members of the supervisory staff of the Division. If dissatisfied with the finding of the administrative review, I will be granted an opportunity for a fair hearing before the Department's Hearing Officer.
11. All information received by the Division is confidential and will only be released upon receipt of a signed release form.
12. I have fully participated in the development of this PROGRAM, and I have received a copy of this document.

REHABILITATIVE SERVICES DIVISION WILL NOT DISCRIMINATE AS TO ACCEPTANCE DETERMINATION, SERVICES, OR EMPLOYMENT IN REGARD TO RACE, COLOR, CREED, SEX, AGE OR HANDICAP.

\_\_\_\_\_  
(Counselor Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Client Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Supervisor Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Client Representative or Witness Signature)

PROGRAM AMENDMENT TO THE  
INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM

(Last Name)

(First)

(Middle)

It has become necessary to amend the INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM for this applicant/client. This AMENDMENT applies to:

- ☐ 1. Current IWRP (including goal changes)  
☐ 2. Current IWRP for extended evaluation service(s)  
☐ 3. Post-employment program

A. This AMENDMENT provides for additional service(s) not included in the current INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM.

LONG-RANGE VOCATIONAL OBJECTIVE: \_\_\_\_\_ DOT CODE: \_\_\_\_\_

INTERMEDIATE REHABILITATION GOALS & OBJECTIVES:

JUSTIFICATION FOR ADDITIONAL SERVICES:

ADDITIONAL REHABILITATION SERVICE(S) TO BE PROVIDED			
LIST ALL PLANNED SERVICES, VENDORS & THE ESTIMATED COST OF EACH SERVICE	ESTIMATED COST	PROJ. DATES OF EACH SERVICE	
		FROM:	TO:

APPLICANT/CLIENT PARTICIPATION IN COST OF SERVICES: *(Include similar benefits)*

CLIENT'S OPINION OF REHABILITATION PROGRAM:

It is understood by the applicant/client that this PROGRAM AMENDMENT only provides for the Vocational Rehabilitation Services as listed on this PROGRAM AMENDMENT document. All other aspects of this PROGRAM will remain the same as identified and set forth on the ORIGINAL INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM.

I have fully participated in the development of this PROGRAM AMENDMENT to my INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM and I have received a copy of this document.

\_\_\_\_\_  
(Counselor Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant/Client Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Supervisor Signature)

\_\_\_\_\_  
(Applicant/Client's Rep. or Witness Signature)

B. This AMENDMENT constitutes the certificate of ineligibility and records the ineligibility findings of the applicant for Vocational Rehabilitation Services. It provides the counselor's rationale for this determination and sets forth "the views" of the applicant, or his representative, concerning this decision.

- ☐ 1. Closure from extended evaluation status  
☐ 2. Closure in status 28 ☐ or status 30 ☐

1. Counselor's Recorded Rationale for the Determination of Applicant's Ineligibility: *(Attach sheets to Written AMENDMENT, if necessary)*

2. Recorded Views of the Applicant, or his Representative, Concerning the Determination of Ineligibility for further Vocational Rehabilitation Services: *(Attach sheets to Written Program Amendment, if necessary)*

\_\_\_\_\_  
(Counselor Signature)

\_\_\_\_\_  
(Applicant/Client Signature)

\_\_\_\_\_  
(Supervisor Signature)

\_\_\_\_\_  
(Applicant/Client's Rep. or Witness Signature)

C. This AMENDMENT records the client's closure in rehabilitated status (VR 26).

1. Occupation at closure: \_\_\_\_\_  
2. Length of time in current occupation: \_\_\_\_\_

EXPLANATION & JUSTIFICATION OF HOW REHABILITATION SERVICES  
CONTRIBUTED TO THIS EMPLOYMENT:

\_\_\_\_\_  
(COUNSELOR)

\_\_\_\_\_  
(DATE)

# CHECKLIST

FOR INDIVIDUAL Written Rehabilitation Pgm. PLAN OF  
Rehabilitative Services Division

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service?	(X)	( )
16. Does the plan specify the duration of each service?	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )





DEVELOPMENTAL DISABILITIES DIVISION  
AND  
SOCIAL SERVICES BUREAU

STATE OF MONTANA  
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

INDIVIDUAL HABILITATION PLAN

☐ INITIAL ☐ REVIEW

\_\_\_\_\_(DATE)\_\_\_\_

CLIENT: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

K NO: \_\_\_\_\_

SSN: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

CASE MANAGER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE NO: \_\_\_\_\_

HABILITATION PLANNING TEAM PRESENT

Name

CLIENT.....

CASE MANAGER.....

PARENTS.....

RESIDENCE STAFF.....

DAY PROGRAM STAFF.....

STATUS OF OBJECTIVES SET  
AT LAST I.H.P. MEETING (\_\_\_/\_\_\_/\_\_\_)

---

SHORT-RANGE GOAL: (Code No. \_\_\_\_\_)

IMPLEMENTATION DATE: \_\_\_/\_\_\_/\_\_\_

ESTIMATED COMPLETION DATE: \_\_\_/\_\_\_/\_\_\_

STATUS:

COMMENTS:

---

SHORT-RANGE GOAL: (Code No. \_\_\_\_\_)

IMPLEMENTATION DATE: \_\_\_/\_\_\_/\_\_\_

ESTIMATED COMPLETION DATE: \_\_\_/\_\_\_/\_\_\_

STATUS:

COMMENTS:

---

SHORT-RANGE GOAL: (Code No. \_\_\_\_\_)

IMPLEMENTATION DATE: \_\_\_/\_\_\_/\_\_\_

ESTIMATED COMPLETION DATE: \_\_\_/\_\_\_/\_\_\_

STATUS:

COMMENTS:

---

SHORT-RANGE GOAL: (Code No. \_\_\_\_\_)

IMPLEMENTATION DATE: \_\_\_/\_\_\_/\_\_\_

ESTIMATED COMPLETION DATE: \_\_\_/\_\_\_/\_\_\_

STATUS:

COMMENTS:

## CLIENT GOALS FOR NEXT SIX MONTHS

---

LONG-RANGE GOAL:

---

SHORT-RANGE GOAL:

CODE NO. \_\_\_\_\_

IMPLEMENTATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ ESTIMATED COMPLETION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PROGRAM/PERSON RESPONSIBLE:

---

SHORT-RANGE GOAL:

CODE NO. \_\_\_\_\_

IMPLEMENTATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ ESTIMATED COMPLETION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PROGRAM/PERSON RESPONSIBLE:

---

SHORT-RANGE GOAL:

CODE NO. \_\_\_\_\_

IMPLEMENTATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ ESTIMATED COMPLETION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PROGRAM/PERSON RESPONSIBLE:

---

SHORT-RANGE GOAL:

CODE NO. \_\_\_\_\_

IMPLEMENTATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ ESTIMATED COMPLETION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PROGRAM/PERSON RESPONSIBLE: -383-

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MEDICAL STATUS & GOAL(S):

---

ADMINISTRATIVE GOAL(S):

---

COMMENTS (CLIENT'S):

---

COMMENTS (OTHER):

---

CLIENT NEEDS NOT ADDRESSED IN THIS PLAN

Need

Limitations or Conditions Which  
Prevent Need From Being Addressed

1.

2.

3.

4.

-384-

5.

I have participated in the development of the habilitation plan designed for me on this date by my habilitation planning team. It has been explained to me and I agree with the long and short range goals outlined. I also agree to participate in the programs which have been recommended by my habilitation planning team.

It has been explained that the intended purpose of this plan is to help me to achieve greater independence and that I, or any member of my team, may request another meeting within the next six months to make major changes in this plan.

It has also been explained to me that information about the amount of time I spend in these programs and the amount of progress I show in them will be monitored by the Developmental Disabilities Division and may be electronically stored for future use. I have been assured that this information will only be used by persons authorized to do so.

Finally, it has been explained that each member of my habilitation planning team will receive a copy of this plan.

\_\_\_\_\_  
(CLIENT'S SIGNATURE)

\_\_\_\_\_  
(DATE)

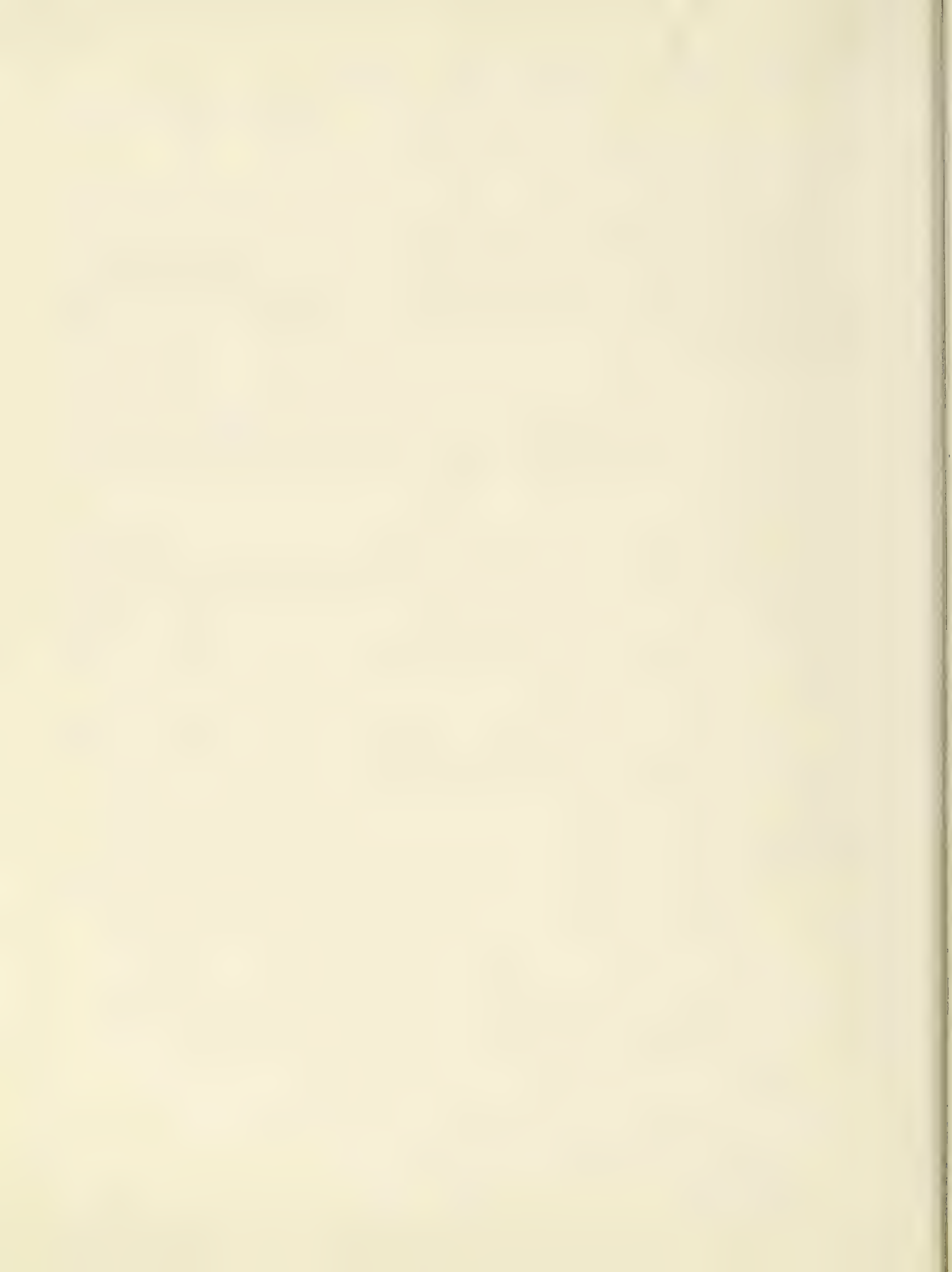
\_\_\_\_\_  
(CASE MANAGER'S SIGNATURE)

\_\_\_\_\_  
(DATE)

ESTIMATED QUARTERLY REVIEW DATE: \_\_\_\_\_

ESTIMATED SEMI-ANNUAL REVIEW DATE: \_\_\_\_\_





# CHECKLIST

## FOR INDIVIDUAL      Habilitation      PLAN OF Developmental Disabilities Division

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative. (and others)	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	( )	(X)
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved? (within review process)	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service? (in some cases)	( )	(X)
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service? (if one is set)	(X)	( )
16. Does the plan specify the duration of each service? (in some cases)	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )

# CHECKLIST

FOR INDIVIDUAL Habilitation PLAN OF  
Social Services Bureau

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service?	(X)	( )
16. Does the plan specify the duration of each service?	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	( )	(X)

There are special forms  
used in IHP team meetings  
which address these issues

## Boulder River School and Hospital

MONTHLY DOCUMENTATION OF REVIEW OF I.H.P. Name: \_\_\_\_\_

## INDIVIDUAL REHABILITATION PLANS

Each person residing at Boulder River School and Hospital has an Individual Habilitation Plan. An interdisciplinary team sets long and short range goals at scheduled IHP meetings. Monthly updates and a yearly review are required on each IHP. (See attached sample copy of the Individual Habilitation Plan form).

The Plan of Service consists of: (1) prioritized needs to be provided the individual and unmet needs; (2) names of persons and departments responsible for training; (3) training schedules (hours per day, days per week, phase and step information, entry date and exit date); and (4) criteria for placement from Boulder River School and Hospital.

[illegible]

HABILITATION NEEDS AND PRIORITIES FOR: \_\_\_\_\_ CASE # \_\_\_\_\_  
IHP DATE: \_\_\_\_\_ COTTAGE NO. \_\_\_\_\_

HABILITATION NEEDS

SERVICE AREA

PRIORITY NO.

Contains a detailed listing of all needs identified for the individual, the service area responsible for meeting each need and the priority (1 thru 3) as defined by the Habilitation Planning Committee at the staffing.

All #1 priority needs which are not being met are listed separately with documentation as to why this priority need cannot be met at this time.



NOTES FROM HABILITATION PLANNING COMMITTEE MEETING

For \_\_\_\_\_, Date \_\_\_\_\_

CONTAINS NOTES FROM THE STAFFING DEVELOPED  
BY THE INDIVIDUAL'S COTTAGE SUPERVISOR

\_\_\_\_\_  
(Signature of Cottage Supervisor)

\_\_\_\_\_  
(Signature of I.H.P. Coordinator)

RESIDENT'S NAME: \_\_\_\_\_

IHP DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

COTTAGE \_\_\_\_\_

MEDICAL REPORT BY: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICATION: \_\_\_\_\_

NEEDS AND LIMITATIONS:

1. (CONTAINS A DETAILED LISTING OF MEDICAL NEEDS AND LIMITATIONS)
- 2.
- 3.
- etc.

SOCIAL SERVICES I.H.P. EVALUATION BY: \_\_\_\_\_

LEGAL GUARDIAN: \_\_\_\_\_

NEED FOR A RESPONSIBLE PERSON: \_\_\_\_\_

PLACEMENT PLANNING: \_\_\_\_\_

FINANCIAL STATUS: \_\_\_\_\_

CHECKING  
SAVINGS

(CONTAINS INFORMATION ON ANY PLACEMENT PLANNING COMPLETED  
OR IN PROCESS)

-391-

Referral Written: \_\_\_\_\_

Sent: \_\_\_\_\_

UPDATED \_\_\_\_\_

RELEASE DATE \_\_\_\_\_

ATTENDANCE SHEET FOR HABILITATION PLANNING MEETING

FOR \_\_\_\_\_ CASE NO. \_\_\_\_\_ IHP DATE \_\_\_\_\_

(CONTAINS SIGNATURE AND WORK AREA OR AFFILIATION OF EVERY  
PERSON AT THE STAFFING)

# CHECKLIST

FOR INDIVIDUAL Habilitation PLAN OF  
Boulder River School & Hospital

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service?	(X)	( )
16. Does the plan specify the duration of each service?	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )

EASTMONT TRAINING CENTER  
CASE STUDY COMMITTEE  
DATE 1/22/80

NAME [REDACTED] DOB 2/20/55 CA# 39 ADDRESS Glendive, MT  
REASON FOR MEETING: First Case Review

IN ATTENDANCE/POSITION: JP Noonan HC  
Russell J. Molstad, S.W.I. Judy Kramer Teacher  
Bonnie Jones S.W.I. Jaci & Lynn HAZ  
Merrill Fahlstrom Sp. Lang. Path. Robert S. Campbell  
Pete Barthel Teacher Sharon Reynolds Teacher  
William K. Fox Rec. Mgr. Least Restrictive Alternative Leanne Subject RV

<u>Date</u>	<u>Residential</u>	<u>Academic</u>	<u>Vocational</u>
-------------	--------------------	-----------------	-------------------

Placement  
Goal

Other Alternative/Discussion

[REDACTED] is on Benzoyl Peroxide 5% for acne. He has cataracts in his eyes  
and tubes in his ears. He should not swim or get water in his ears.  
Everyone should informally discourage [REDACTED] teeth grinding by holding  
his jaw lightly and saying, [REDACTED] don't grind your teeth."

Russell J. Molstad  
Social Worker I



Habilitation Program

                     CA#39

<u>Priority Area</u>	<u>Priority Objective</u>	<u>Responsible Party</u>
<u>Pre-Vocational,</u>		<u>Sharon Reynolds</u>
<u>Homeliving</u>		
<u>Functional Communication</u>		<u>Barbara Jessen</u>
<u>Individual Communication</u>		<u>Merrill Fahlstrom</u>

I agree with the goals set up by the committee as appropriate and adhering to the concepts of the least restrictive alternative.

Signed *[Signature]* Chairman *[Signature]*

██████████  
Case #39

1st Case Review

### Self-Help

██████████ is a self-help pullout four times a week. He has met his objective which was to cross his shoe laces to prepare for tying. ██████████ has graduated from his shoe tying program and is now on a maintenance program to retain this skill. A baseline was taken for toothbrushing on ██████████ and baseline data showed that ██████████ has apparently received training in this area previously. He is aware of the sequence involved but needs assistance in brushing thoroughly. This program was not formally initiated.

Judy Kramer  
Teacher

### Pre-Vocational

██████████ achieved his objective which was to complete one-to-one correspondence tasks by placing two objects onto a marked jig without prompts. He is able to place 5 chips on each mark, but when the trainer changed the objects it confused him and he needed verbal prompts and gestures. If ██████████ is given something to do he enjoys, he will do it until the trainer takes it away from him; and if he is given a harder task he will try for awhile and then push it away. ██████████ interacts with other peers by taking their arm and shaking it so their hand will flap back and forth. It is felt by the trainer that this is inappropriate and ██████████ should be taught a correct way of interacting. It is recommended ██████████ continue in the pre-vocational area with emphasis on attending skills.

Rita Barthel  
Teacher

### Pre-Language

██████████ met his first objective to learn two new signs. ██████████ did not meet his second objective for two-word sign utterances. He seemed to mix up the signs as new ones were introduced. I feel that the two-word utterance level was too high for his limited vocabulary. ██████████ seems interested in working with objects and generally kept busy during class.

Recommendations: Continue training in sign, to expand vocabulary.

Barbara Jessen  
Education Director

Case #39  
1st Case Review

### Home Living

In the area of home living, [REDACTED] has achieved his objective in that he is able to fold a T-shirt independently with 100% accuracy. [REDACTED] informally worked on folding other articles of clothing including long pants and undershorts. [REDACTED] did very well in these programs.

[REDACTED] has been working on setting the table the last two weeks of this quarter but has great difficulty with this task.

I recommend that [REDACTED] continue in the home living area with further emphasis placed on table setting. I would also like to see [REDACTED] placed in either Cottage I or II for at least one meal during the day as I feel it would greatly enhance his social skills to be able to eat with people who have some communication skills in signing.

I also recommend that [REDACTED] continue to be involved in a pre-vocational classroom.

Sharon Reynolds  
Teacher

### Communication

[REDACTED]'s communication objectives were to produce two additional signs with 60% accuracy and to sign for things he wants using the phrase, "I want \_\_\_\_." [REDACTED] has mastered the sign for "bathroom" and uses the sign spontaneously for self initiation. He is producing the sign for "music" at a 60% accuracy level. He has thus achieved his first objective. Training for the sign "music" will continue, to raise the criterion level. The sign for "coat" was also added to [REDACTED]'s manual communication program and he is presently producing the sign with a partial physical prompt. When [REDACTED] came to the Center, he demonstrated the ability to produce, "I want \_\_\_\_," when some foods were presented; however, this is not elicited on a consistent basis. Using the phrase, "I want \_\_\_\_," occurs at the meal table most frequently and the trainer does not feel that he understands the meaning of "want," but rather has learned "want \_\_\_\_" as a two-part word. This is supported by the fact that [REDACTED] does not use the phrase, "want \_\_\_\_," when asked what he wants when other objects and edibles are presented. This program was terminated mid-term.

Case #39  
1st Case Review

Communication (continued)

█ has proven to be a difficult student to motivate. An informal reinforcement probe was administered and the only items which the trainer found █ to be interested in were as follows: music box, pop, running, jumping, and having his head scratched/rubbed. He did not respond to any toys or edibles presented. He did not like to be tickled. These reinforcers do not appear to be consistently reinforcing for █ in a 1-1 situation.

Merrill Fahlstrom, M.S.  
Speech-Language Pathologist

Recreation

█ has two objectives in the recreation area. They are, 1) to have the working knowledge of one active and one passive activity, and 2) to participate in one large group activity.

He is involved in a recreation group for an active activity (relay races; musical chairs) and a passive activity (rhythm instruments); however, the progress is only fair.

█ is also involved in a large group bowling session each Thursday morning. He likes bowling and will participate in it much more actively than in a regular recreation class.

█ seems to be very slow at learning and especially so if he does not want to participate.

I recommend that █'s new goal for recreation be changed to read: "█ will participate in a small group recreation class 30 minutes a day, six days a week for social peer interaction."

William K. Fox  
Recreation Therapist



EASTMONT TRAINING CENTER  
INTERDISCIPLINARY TEAM MEETING  
DATE 11/20/79

NAME: [REDACTED] B/D 2/20/55 ADDRESS Glendive, MT

IN ATTENDANCE/POSITION

Robert L. Campbell

Bjorn - Ed [unclear] Lydia [unclear]

Robert L. Campbell

Donald F. Battler

Russell J. Molstad, S.W.I.

PROGRESS REPORT/COMMENTS

[REDACTED] is in home living and making slow progress. He is doing very well in pre-language on one objective; however, the other objective will be changed. He is making satisfactory progress in recreation. In pre-vocational class he is making slow progress. He has improved in bed making and eating skills in the cottage. He has learned to hang up his coat and has receptive language skills, following simple commands.

Russell J. Molstad  
Social Worker I



EASTMONT TRAINING CENTER  
INTERDISCIPLINARY TEAM MEETING  
DATE 10/2/79

NAME:                      B/D                      ADDRESS                     

IN ATTENDANCE/POSITION

<u>Robert H. Lord</u>	<u>Russell J. Molstad, S.W.I.</u>
<u>William K. Fox, Rec. Therapist</u>	<u>Phyllis Kay, Teacher</u>
<u>Jane Mast, Teacher</u>	<u>Richard Barrett, Teacher</u>
<u>                    </u>	<u>Judy Kramer, Teacher</u>
<u>                    </u>	<u>Merrill Fahlstrom, Sp. Ed. Tech.</u>

PROGRESS REPORT/COMMENTS

Rita Barthel, Teacher, reported on signing "candy," "cracker," and "music." Music is being used as a reinforcer.            is making steady progress and in pre-vocational he is working on attending skills. It is hard for            to develop his fine motor skills. He is very independent in his play activity and only wants to do certain things. His favorite is simple puzzles. Jane Mast reported on community orientation with           . He has been downtown several times and is well behaved. Bill Fox, recreation specialist, reported on           's flapping and shaking of other residents' hands. He always wants the other residents to interact with him but they seldom respond.            will be spending more time interacting with the 5-day residents who will respond during leisure time. Merrill Fahlstrom reported on            achieving the sign for "bathroom." Jackie Wurm noted he is self-initiating his trips to the bathroom. He also helps make his bed in the morning and is becoming skillful in these areas.

Russell J. Molstad  
Social Worker I

EASTMONT TRAINING CENTER  
CASE STUDY COMMITTEE

DATE 8/13/79

DOB

NAME [REDACTED] CA 2/20/55 ADDRESS Glendive, Montana

REASON FOR MEETING: to establish an Individual Habilitation Plan  
for 1979-80.

IN ATTENDANCE/POSITION:

Gerald F. Butler, Supt. [REDACTED] [REDACTED]  
Russell J. Mallett, S.W.I. [REDACTED] [REDACTED]  
[REDACTED] Teacher Judy Kramer Teacher  
[REDACTED] [REDACTED] [REDACTED]

Least Restrictive Alternative

<u>Date</u>	<u>Residential</u>	<u>Academic</u>	<u>Vocational</u>
<u>7/1979</u>	<u>B.R.S. &amp; H.</u>	<u>B.R.S. &amp; H.</u>	<u>B.R.S. &amp; H.</u>
<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
<u>Placement</u>			
<u>Goal</u>	<u>1979/80</u>	<u>E.H.S.C.</u>	<u>E.H.S.C.</u>
		<u>E.H.S.C.</u>	<u>E.H.S.C.</u>

Other Alternative/Discussion

[REDACTED] was present for this meeting. His parents, [REDACTED]  
[REDACTED], were notified of this meeting and invited to attend.  
[REDACTED] receives no ongoing medication and will receive a dental and  
optometric examination later in the year.  
Baseline programming will begin immediately and formal programming  
will begin on 8/27/79.

Pamela Rodgers  
Administrative Officer IV

Habilitation Program

<u>Priority Area</u>	<u>Priority Objective</u>	<u>Responsible Party</u>
<u>Pre-Vocational</u>	<u>Increase attending skills</u>	<u>Sharon Reynolds</u> <u>Rita Barthel</u>
<u>Home Living</u>	<u>Increase domestic skills</u>	<u>Sharon Reynolds</u> <u>Rita Barthel</u>
<u>Communication</u>	<u>Expansion of expressive</u> <u>manual communication</u>	<u>Merrill Fahlstrom</u>

I agree with the goals set up by the committee as appropriate and adhering to the concepts of the least restrictive alternative.

Signed

Chairman

EASTMONT HUMAN SERVICES CENTER

HABILITATION PLAN

CASE NUMBER: 39  
NAME: [REDACTED]  
BIRTHDATE: 2/20/55  
ADDRESS: Glendive, Montana  
DATES OF EVALUATION: July 30-August 10, 1979  
DATE OF REPORT: August 13, 1979

STATEMENT OF STRENGTHS AND WEAKNESSES

Academic Readiness

[REDACTED] was given a formal test in Academic Readiness and observed in free time. He was able to establish eye contact on the verbal cue, "[REDACTED], look." [REDACTED] was able to pick up and mark with a crayon and follow simple commands such as, "Stand up," "Sit down," and "Come here." He was also able to imitate clap hands, raise hands and stand up, but not sit down. [REDACTED] was able to locate his head but unable to locate any other body parts. He was able to match a spoon but unable to match other common objects or pictures. [REDACTED] identified the spoon by auditory cue but was unable to identify other common objects by auditory cue or visual memory. He sat very quietly during the evaluation and seemed to like music as a reinforcement.

Recommendations: It is recommended [REDACTED] be in a pre-language program with emphasis on manual communication. It is further recommended [REDACTED] be in an Academic classroom and work on functional writing.

Rita J. Barthel  
Teacher

Academics

[REDACTED] is capable of putting an 8 piece puzzle together, stringing beads and holding a scissors correctly. He can only cut into the paper once. [REDACTED] can also put pegs into a large pegboard, but he cannot copy a design.



Academics (continued)

Recommendations: It is recommended that [REDACTED] be placed in a pre-language or pre-academics class.

Sue Satterfield  
Teacher

Self-Help

[REDACTED] was given the CAMS Self-Help Test for the Mentally Retarded.

Feeding: [REDACTED] is an independent eater but must be supervised due to inappropriate table manners such as eating too much at one time and eating too fast. He is able to use his fork and spoon correctly, but needs assistance when cutting with his knife. [REDACTED] is able to drink from a glass and pour from a pitcher with little or no spilling. He is able to clear own place setting when finished eating.

Dressing: [REDACTED] is able to dress and undress without assistance. He is able to lace and put on his shoes but is unable to tie them. [REDACTED] likes to choose the clothing he wears. If staff sets out clothing for him he will put them away, select what he wants to wear. [REDACTED] has all of his fastening and unfastening skills except for engaging a zipper.

Personal Hygiene: [REDACTED] is able to wash his hands and face but will not use soap or dry them well enough. He needs supervision while bathing or he will not bathe adequately. [REDACTED] will dry himself if prompted. He does not prepare the tub for his bath or regulate the water temperature. [REDACTED] seems to enjoy his bath and is very cooperative while bathing. [REDACTED] needs assistance while brushing his teeth to maintain good oral hygiene. [REDACTED] needs complete physical assistance when shampooing his hair, combing his hair and shaving.

Toileting: [REDACTED] is completely independent in toileting skills. He also has the secondary skills such as using toilet tissue, flushing the toilet and washing hands after toilet use. [REDACTED] has the idea of washing his hands but does not use soap. [REDACTED] does not have accidents.

Recommendation: It is recommended that [REDACTED] be placed in Self-Help programming to increase independence in secondary dressing and secondary eating skills.

Judy Kramer  
Teacher



### Pre-Vocational Training

██████ was given the Michigan State Pre-Vocational Assessment for the Severely Mentally Retarded Student using Level III for the majority of the test. He completed the fine motor assessment which was the grasp, carry and release of objects. ██████ did very well in two areas of job skills; Eye/Hand Coordination/One Hand and Visual Discrimination/Object Sort. He completed both of these tasks with persistence. He showed no skills in Eye/Hand Coordination/Two Hands and Visual Discrimination by size and shape. ██████ was cooperative throughout the evaluation, but attention span was very low, and prompting was needed for ██████ to stay on track.

Recommendation: It is recommended that ██████ be placed in a Pre-Vocational Program with emphasis on Eye/Hand Coordination/Two Hands and attending to a task.

Judy Kramer  
Teacher

### Home Living

██████ was tested in the area of home living through an evaluation taken from the Boulder River School and Hospital Assessment. ██████ was able to complete beginning skills in all areas of home living but the area of domestic skills seemed to be the highest area.

In the area of clothing care, ██████ was unable to fold or hang any clothing:

In home cleaning and kitchen cleaning, ██████ was unable to wash tables or set tables. He was also unable to dust furniture or make beds.

██████ did not have any skills in the area of cooking.

Recommendations: I recommend that ██████ be involved in a home living class with emphasis in the clothing care area and work on folding and hanging clothes. I would also like to see ██████ be placed on a table washing and setting program.

Sharon Reynolds  
Teacher

### Community Orientation

█'s behavior was very good. He rode well and was compliant. He became fascinated with overhead lights in Safeway. He went through check out line and made a purchase; trainer had to help him with change. After prompting, he carried package. He rode well in an elevator but showed no understanding of operation. He walked within pedestrian cross walk, did not look both ways for cars. Can use straw but drank Coke from glass, manners were good, neat, and he showed interest in surroundings.

Recommendations: I recommend that █ be placed in a language program with emphasis on expressive communication skills.

I also recommend that █ be taken into the community at least twice a week.

Jane Mast  
Teacher

### Social Skills

█ reacts and interacts with staff and peers. He responds to his name, touch, tickles, image in a mirror. He follows simple commands and is compliant. He grasps and shows interest in objects. He establishes eye contact, and will show response to speaker in a group. He turns in response to both loud and quiet noises. He tracks and fixates on colored stationary objects. He will take out and replace blocks from a box. He waved and clapped his hands. He needs prompting to join a group. He needed physical prompt to find body parts; head, nose, mouth, but he pointed to his eyes and ears with verbal prompt.

Recommendations: I recommend a language program with emphasis on expressive communication skills. Informally, he needs to be placed in small group activities.

Jane Mast  
Teacher

### Communication

█████ was assessed using Eastmont's Communication checklist. █████ entered the evaluation session willingly and responded to all demands made by the examiner. During the evaluation █████ was curious and interested in his surroundings as well as objects presented. █████ displayed the maladaptive behaviors of teeth grinding, swinging his arms, hand fixation, hand manipulation and putting his index finger in his mouth during the evaluation session. These behaviors were easily extinguished by telling █████ "no" or redirecting him to tasks.

█████'s pre-language sensorimotor skills were assessed using the Uzgiris and Hunt sensorimotor scales of development. In Scale I (visual pursuit and object permanence) █████ was able to visually track an object's movement through a complete arc as well as following it to its point of disappearance. He demonstrated the ability to systematically search for and obtain objects when complex hiding strategies were used, thus indicating acquisition of the concept of object permanence. In Scale II (means for obtaining desired environmental events) █████ demonstrated reaching, repeating actions, the use of a support and the use of a string as means for obtaining objects. He was unable to consistently demonstrate the use of foresight in problem solving situations. In Scale III (vocal/gestural imitation) █████ did not attempt to imitate any sounds, sound patterns or words presented. In gestural imitation, █████ was able to imitate all gestures presented. In Scale IV (development of operational causality) █████ attempted to reinstate both the examiner's and object's action. In Scale I (construction of object relations in space) █████ was able to alternate his glance between two objects, localize to sound, grasp objects, recognize the reverse side of an object, understand the relationship of the container and the contained, build a block tower and make a detour around a barrier to obtain an object. He had difficulty following the trajectory of a falling object. In Scale VI (schemes for relating to objects) █████ exhibited holding, visual inspection, shaking, waving, hitting two objects together, sliding, tearing and dropping as schemes for relating to objects. The only socially instigated action noted was kissing a doll.

In the CAMS receptive language checklist, █████ attended to sound, looked at objects on command, responded to his name, followed the one-concept commands, "Stand up," "Come here," and "Sit down," without gestures and identified a spoon, toothbrush, cup, comb, soap and shoe. He was also able to follow other commands when gestures were used. The only body part █████ was able to identify was his head. In the picture communication assessment, █████ was able to match object to object and object to picture. Matching picture



### Communication (continued)

to object was easily trained through the use of gestural prompting. He was unable to match picture to picture.

Expressively, [REDACTED] did not produce any verbalizations during the evaluation. He spontaneously signed "pop," "candy," "cracker," "please," "drink," and "eat." He was able to sign the phrase, "I want \_\_\_ please," with prompts. He spontaneously imitated signs he was unfamiliar with. He also uses gestures such as holding his hand out for things he wants and pushing away undesired objects.

Results of this assessment indicate that [REDACTED] has developed the sensorimotor skills necessary for development of a language system. His receptive and expressive language are both limited.

Recommendations: 1) It is recommended that [REDACTED] be enrolled in an individualized communication training program under the direction of the Speech-Language Pathologist. Training emphasis should be placed on command following, manual signing, object identification, matching and object manipulation.

2) It is recommended that [REDACTED] be placed in a sign group in the Academic classroom for generalization purposes.

3) It is recommended that [REDACTED] receive a hearing evaluation as a part of his evaluation.

4) It is further recommended that staff use manual sign when communicating with [REDACTED] as he appears to respond better to manual signs.

Merrill Fahlstrom  
Speech-Language Pathologist

### Recreation

[REDACTED] was evaluated in the fine motor and gross motor areas of recreation using the CAMS Motor Program. Throughout the testing period, [REDACTED] was compliant and happy going. He did display teeth grinding but when asked to stop, he did so. In the gross motor area, [REDACTED] was able to roll from side to side, back to side and stomach to back. He was able to assume, maintain and move in a crawling and creeping position. [REDACTED] had the ability to maintain himself on his

Recreation (continued)

stomach with elbows straight and legs straight behind. He was able to walk five steps backwards unassisted and run. [REDACTED] was able to jump up and down; however, would not jump from a platform nine inches high. He displayed the ability to hop forward and ride a bike by pushing the pedals. He was unable to skip, walk lame duck fashion or walk within two parallel lines eight inches apart.

When tested in the fine motor area, [REDACTED] was able to reach using rake and pincer motions, pick up and hold two objects. He had the ability to transfer an object from one hand to the other, hit two objects together and clap his hands on command. [REDACTED] was able to fill, remove and dump objects from a container. He had the ability to build a tower of eight blocks; however, was unable to align two blocks or make a bridge. [REDACTED] was able to catch, kick and throw a ball. He had the ability to turn pages of a book one at a time and turn a door knob to open a door. He was able to scribble when shown how, but was unable to copy a circle, square, cross or vertical and horizontal lines when shown how.

Recommendations: It is recommended that [REDACTED] participate in a large group recreation class, emphasis on peer interaction, play skills, and proper use of recreational equipment and time.

Candace Eide  
Recreation Specialist



NAME: [REDACTED]

ART: SELF-HELP

RESPONSIBLE PERSON: Judy Kramer  
Jane Mast

## OBJECTIVES AND GOALS

Departmental Goal: [REDACTED] will receive a minimum of four hours training daily.

Goal: to increase secondary dressing skills.

Objective: [REDACTED] will be able to grasp laces, pull laces tight and cross laces correctly with 70% accuracy by 12/1/79.

- - - -

Goal: to increase secondary hygiene skills.

Objective: to be able to brush teeth thoroughly with minimal physical assistance.

Objective: to be able to tie shoes independently by 1/1/80  
1/22/80

Objective: to maintain shoe tying

1st Review

achieved

not  
initiated

achieved

2nd Review

3rd Review

NAME: [REDACTED]

AREA: PRE-VOCATIONAL

RESPONSIBLE PERSON: Sharon Reynolds

Sharon Reynolds

Rita Barthel

OBJECTIVES AND GOALS

Departmental Goal: [REDACTED] will receive a minimum of four hours training daily.

Goal: to increase attending skills.

Objectives: to complete one-to-one correspondence tasks by placing two objects onto marked jig without prompts by 12/1/79.

achieved

1/22/80

Objective: to complete a three-step operation in the one-to-one correspondence area using one minimal prompt back to task each trial by April, 1980

3rd Review

2nd Review

1st Review

NAME:

[REDACTED]

AREA: HOME LIVING

RESPONSIBLE PERSON: Sharon Reynolds

OBJECTIVES AND GOALS

Departmental Goal: [REDACTED] will receive a minimum of four hours training daily.

Goal: to be able to obtain at least three independent living skills in each section of home living.

Objective: to be able to fold a T-shirt using 2 physical prompts by December 1, 1979.

1/22/80

Area Goal: to be able to set one place setting independently

Objective: to be able to place the glass and fork in appropriate place by April, 1980, when setting the table.

1st Review

2nd Review

3rd Review

achieved

NAME:

AREA: FUNCTIONAL  
COMMUNICATION

RESPONSIBLE PERSON:

Judy Kramer

## OBJECTIVES AND GOALS

1st REVIEW

2nd REVIEW

3RD REVIEW

Departmental Goal: [REDACTED] will receive a minimum of four hours training daily.

2/80

Goal: to increase manual communication

Objective: to generalize for "music" to forms other than the music box (i.e., phonograph, radio, tapes) with 60% accuracy by 5/1/80.

Objective: to generalize sign for "drink" to liquids other than pop with 60% accuracy by 5/1/80.

NAME: [REDACTED]

AREA: COMMUNICATION

RESPONSIBLE PERSON: Merril Fahlstrom  
Rita Barthel

OBJECTIVES AND GOALS

Departmental Goal: [REDACTED] will receive a minimum of four hours training daily.

Goal: to expand receptive and expressive language. .

Objectives:

- 1) [REDACTED] will produce two additional signs on command with 60% accuracy by December, 1979.
- 2) [REDACTED] will ask for things he wants using a three word sign utterance (i.e., I want \_\_\_\_ ) with 60% accuracy by December, 1979.

1/22/80

Objectives:

- 1) [REDACTED] will produce two additional signs on command with 60% accuracy by next review date.
- 2) [REDACTED] will receptively identify 1 object with 60% accuracy by next review date.

1st Review      2nd Review      3rd Review

achieved

not achieved



NAME: [REDACTED] APER: RECREATION

RESPONSIBLE PERSON: William Fox  
Candace Eide

OBJECTIVES AND GOALS	1st Review	2nd Review	3rd Review
<p>Departmental Goal: [REDACTED] will receive a minimum of four hours training daily.</p>			
<p>Goal: [REDACTED] will participate in a large group recreation class 60 min. per day, 7 days a week for peer interaction.</p>			
<p>Objectives: 1) [REDACTED] will have the working knowledge of one active and one passive activity by December, 1979. 2) [REDACTED] will participate in one large group activity weekly.</p>	<p>1/22/80 ongoing ongoing</p>		

# CHECKLIST

FOR INDIVIDUAL Habilitation PLAN OF  
Eastmont Training Center

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	( )	(X)
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service?	( )	(X)
16. Does the plan specify the duration of each service?	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )



# WARM SPRINGS STATE HOSPITAL TREATMENT PLAN

Admission Date: Commitment: Commitment Expires:  
 Birthdate: S M W D Religion: Hometown:  
 Next of Kin: County:

## MEDICAL PROGRAM

Allergies: Physical exam by: Date:  
 Diet: Mental Exam by: Date:

CRITERIA FOR DISCHARGE:

AFTERCARE PLAN:

## SPECIAL TESTS

DATE DUE	COMPLETED	DATE DUE	COMPLETED

DIAGNOSIS

DATE	CHANGE OF STATUS	DATE	CHANGE OF STATUS	DATE	CHANGE OF STATUS

ADMISSION TREATMENT PLAN

IMPP APPROVAL:

REASON FOR ADMISSION:

INTERVENTIVE APPROACHES:

PRECIPITATING EVENTS:

## MEDICATIONS

IS ADMISSION APPROPRIATE:

PROBLEM

STRENGTHS

RECOMMENDED PLACEMENT:

STAFF - Supervisor:  
 Physician:  
 Psychologist:

Social Worker:  
 Rehab Therapist:  
 Psychiatric Nurse:

PWU Approval: \_\_\_\_\_  
 Treatment Unit Review Date: \_\_\_\_\_  
 Other Review Date: \_\_\_\_\_

Reason for  
Review

Strengths/  
Capabilities

Significant  
Health  
Problems

Maladaptive  
Behavior/  
Problems

Treatment

Approaches

TIME

BY



INSP Approval:

Treatment Unit Review Date:

Medication/  
Physical  
Treatment

Least  
Restrictive  
Environment

Short Term  
Goals

Long Range  
Goals

Target Date

Target Date

Staff:

Supervisor:  
Physician:  
Psychologist:  
Social Worker:

Rehab Therapist:  
Psychiatric Nurse:  
Other:

INSP #

NAME:

## Warm Springs State Hospital Treatment Plan

## Diagnosis

### Long Term Goals

Projected time.

### Short Term Goals

Director

Social Worker

Doc 101

Rehab Therapist

Psychologist

Psychiatric Nurse

Date Due	Service	By	Date Completed
	Physical Examination		
	Mental Examination		
	Treatment Plan		
	Three Month Review		
	Six Month Review		
	Yearly Review		

[illegible]



Medical Program

Allergies

Diet

Physical Limitations

Special Diagnostic Procedures

Date	Test	Date	Test

After Care Plan

Responsible Person

Home Town and County

Commitment

Age Birthdate SMWD Religion

Admission Date

Hosp # Name Region Unit

# CHECKLIST

FOR INDIVIDUAL Treatment PLAN OF  
Warm Springs State Hospital

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities; (if possible)	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	( )	(X)
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	( )	(X)
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	( )	(X)
9. Does the plan contain a schedule for the evaluation procedure?	( )	(X)
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service?	(X)	( )
16. Does the plan specify the duration of each service?	( )	(X)not
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	always
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )

Requires 3 month review  
for year - then annual.







# MONTANA SCHOOL for the DEAF and BLIND

3011 CENTRAL AVENUE

PHONE 453-1401

GREAT FALLS, MONTANA 59401

FLOYD J. McDOWELL, SUPERINTENDENT  
RESIDENCE PHONE 453-4179  
AREA CODE 408

## INDIVIDUAL EDUCATIONAL PROGRAM

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

School \_\_\_\_\_ City: \_\_\_\_\_

Duration of I.E.P. \_\_\_\_\_ to \_\_\_\_\_ Date I.E.P. Written \_\_\_\_\_

Time In Special Class \_\_\_\_\_ Time in Regular Education \_\_\_\_\_

Specific Education and/or Support Services	Time to be provided	Projected Date of Initiation	Duration of Services

Annual Goal # \_\_\_\_:

Date  
Completed

Baseline:

I.E.P. Developed by:

Short Term Instructional Objectives (written in behavioral terms with  
criteria for evaluation of objectives and timeline for evaluation)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Signature	Role	Signature	Role
-----------	------	-----------	------

\_\_\_\_\_  
Administrator or Designee

\_\_\_\_\_  
Regular Education Teacher

\_\_\_\_\_  
Special Education Teacher

Sign the appropriate statement:

I have had the opportunity to participate in the development of this Individual  
Education Program and approve of its content and the educational placement/  
service for my son/daughter.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

I disagree with the Individual Education Program and do not agree to the  
educational placement.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

# INDIVIDUAL EDUCATIONAL PLAN

Date \_\_\_\_\_

[illegible]

School \_\_\_\_\_ Program \_\_\_\_\_

Classroom Teacher \_\_\_\_\_ Aides \_\_\_\_\_

Date of Program Entry \_\_\_\_\_

### Individuals Attending I.E.P. Conference & Signatures

## Annual - Long-Term Goals

## Life Time Goals



Materials and Resources	Review Date	Objective Criterion Level	Objectives Attained
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no
			yes    How measured no



INDIVIDUAL EDUCATION PROGRAM - continued

Summary of Present Educational Performance. (See attached copies.)

CHECKLIST

FOR INDIVIDUAL EDUCATIONAL PLAN OF

DEAF/BLIND PROGRAMS

---

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	(X)	( )
15. Does the plan identify the specific date of initiation of each service?	(X)	( )
16. Does the plan specify the duration of each service?	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )

MATERNAL & CHILD HEALTH BUREAU

SUPPLEMENTAL SECURITY INCOME - DISABLED CHILDREN'S PROGRAM

INDIVIDUAL SERVICE PLAN

Name \_\_\_\_\_ BD \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Case History Obtained (Date) \_\_\_\_\_ On File (where) \_\_\_\_\_

Date of ISP Team Meeting \_\_\_\_\_ SSI-DCP Case Manager \_\_\_\_\_

Participants \_\_\_\_\_ Agency/Position/Phone No. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Assessment of ISP

Estimated Total Cost: \$ \_\_\_\_\_

I/we have reviewed and accepted this ISP which was developed with my participation. I also accept the conditions set forth under rights and responsibilities after reviewing them with my case manager.

Date \_\_\_\_\_ Name \_\_\_\_\_

(Parent/Caretaker)

Lead Agency/Person \_\_\_\_\_

Schedule for Review of ISP \_\_\_\_\_

I/we accept the ISP as revised:

Date \_\_\_\_\_ Name \_\_\_\_\_

(Parent/Caretaker)

Lead Agency/Person \_\_\_\_\_

ISP discontinued \_\_\_\_\_ Reason \_\_\_\_\_

(Date)

Purchase of services discontinued \_\_\_\_\_ Reason \_\_\_\_\_

(Date)

## SSI INDIVIDUAL SERVICE PLAN

I. Name \_\_\_\_\_ BD \_\_\_\_\_ SSN \_\_\_\_\_ ICDA # \_\_\_\_\_  
Parents Name \_\_\_\_\_ HCS# \_\_\_\_\_  
Address \_\_\_\_\_ HCS Eligible yes no  
County \_\_\_\_\_ Center \_\_\_\_\_ Medicaid Elig yes no  
Case Manager \_\_\_\_\_ SSI Elig Date \_\_\_\_\_  
Diagnosis: 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

## II.

EVALUATIONS NEEDED				FINANCIAL INFORMATION	
TYPE	DATE	REPT. REC.	TYPE	DATE	REPT. REC.
DEVELOPMENT			VISION		
AUDIO			SOCIAL		
SPEECH/LANG			NURSING		
O.T.			DENTAL		
PHYSICAL EXM			NUTRITIONAL		
P.T.			EDUCATIONAL		
SPECIAL MED.			PSYCHOL.		
MEDICAL HIST			OTHER		

YES	NO	NAME
		WIC
		AFDC
		CHAMPUS
		FOOD STAMPS
		PRIVATE INS.
		OTHER

## III.

## SERVICES NEEDED (CODE: CURRENT (+) NEEDED (o) )

REHABILITATIVE		SOCIAL		EDUCATIONAL		RESIDENTIAL		VOCATIONAL	
PHYSICIANS	Child Development	Counseling	Reg. Classroom	Reg. Classroom	Nat. Family	Pre-Voc.Tr.			
Medical	Physical Therapy	Legal Aid	Spec. Ed.	Spec. Ed.	Fost. Care	Work Activ.			
Surgical	Occup. Therapy	Citizens Advocate	Comm.Ctr.Prog.	Comm.Ctr.Prog.	Group Home	Workshop			
Medical Spec.	Speech Therapy	Recreation	Home Bound Prog.	Home Bound Prog.	Nurs. Home	Vocational			
HOSPITAL	Hearing Therapy	Personal Develop.	Work Study	Work Study	Other	Other			
Inpatient	Public Health Nurse	Other	Institution	Institution	EQUIPMENT	IMMUNIZATIONS			
OUTPATIENT	Home Health	MENTAL HEALTH	Other	Other	Wheelchair	Completed			
Clinic Visits	Interpreter	Indiv. Counsel.	DENTAL	DENTAL	Braces	Needed			
EEG	Mobility Training	Group Counsel.	Routine Maint.	Routine Maint.	Hearing Aid				
X-rays	Home Training	Other	Orthodontic Care	Orthodontic Care	Glasses				
Lab.	Other		Other	Other	Other				
Other									

## IV.

INDIVIDUAL SERVICE PLANS RECEIVED FROM:		QUARTERLY REVIEWS:		ISP ANNUAL REVIEW:	
TITLE XX	DATE:	NAME:	DATE:	CASE MGR:	REVIEW TEAM: (NAME & FUNCTION)
EDUCATION (IEP)					
DEVELOPMENTAL DISABILITIES (IPP,IHP)					
VOCATIONAL REHABILITATION					
MENTAL HEALTH SERVICES					
HEAD START					
OTHER (IDENTIFY)					

# SSI INDIVIDUAL SERVICE PLAN

NAME: \_\_\_\_\_

DIAGNOSIS	BASIS FOR DIAGNOSIS	PLACE EVALUATED	DATE

## MEDICAL/REHABILITATIVE PROBLEMS

PROBLEMS	OBJECTIVE(S)	INTERVENTION ACTIVITIES/SERVICES	SERVICES PROVIDED BY	COST/ WHO PAYS	ESTIMATED DURATION	STARTING DATE	TERMINATION DATE & REASON
				-----			
				-----			
				-----			
				-----			
				-----			
				-----			
				-----			
				-----			
				-----			



## NAME:

## NAME:

[illegible]

-433-

## SOCIAL/EMOTIONAL PROBLEMS

[illegible]

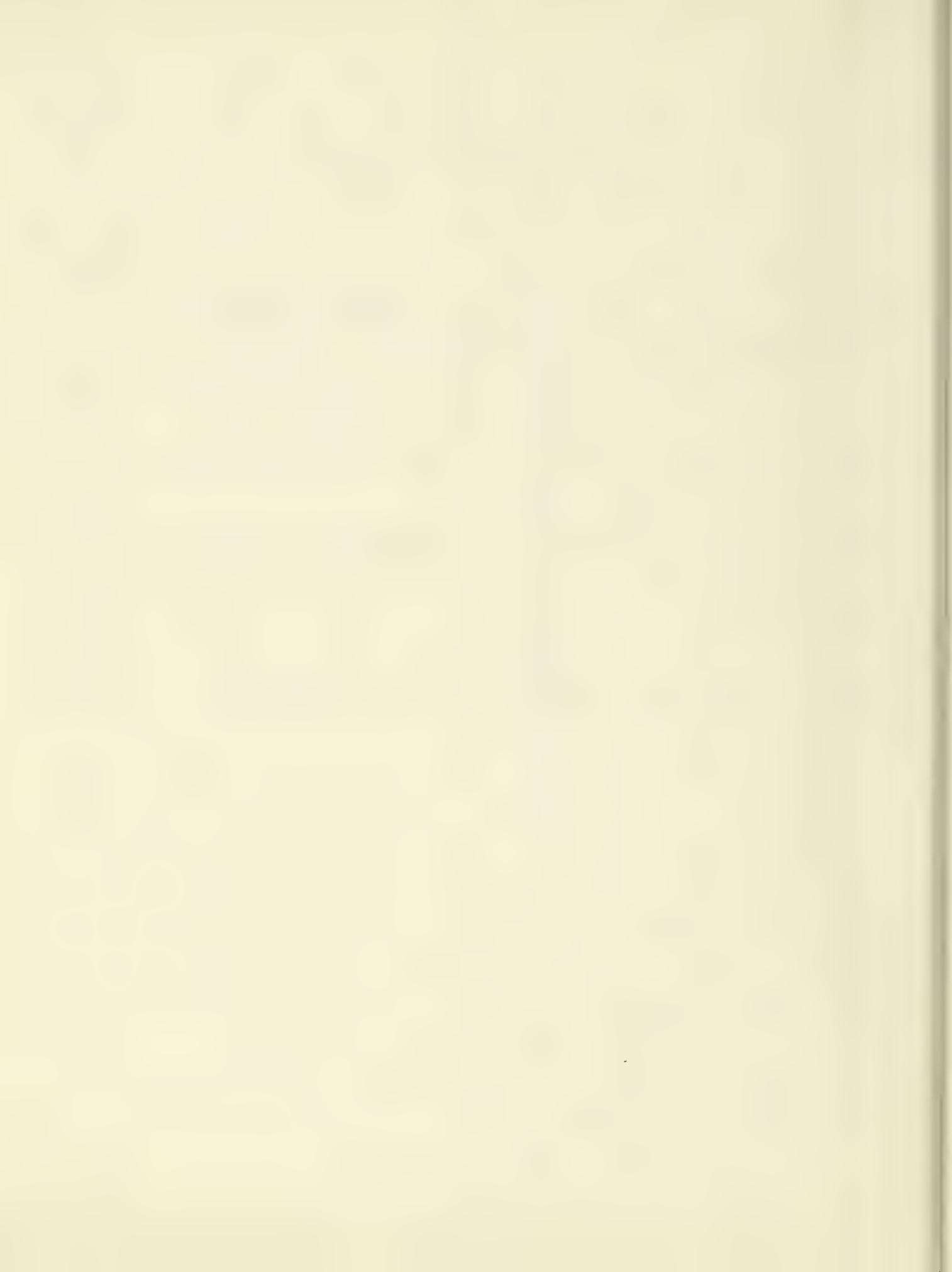
CHECKLIST

FOR INDIVIDUAL                      SERVICE                      PLAN OF

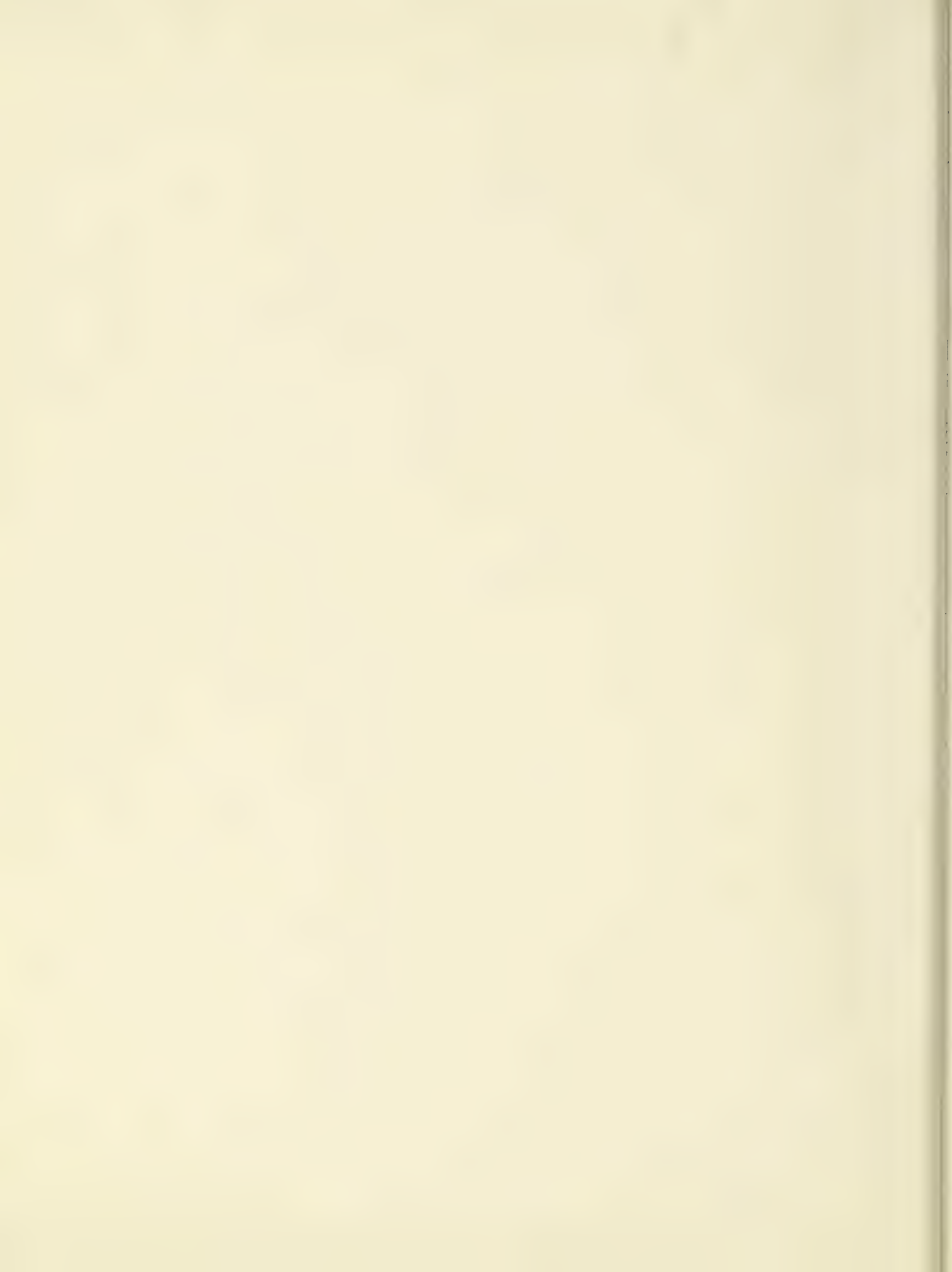
SSI FOR DISABLED CHILDREN PROGRAM

	YES	NO
1. Is the plan in writing?	(X)	( )
2. Has the plan been jointly developed by the following individuals:		
(a) appropriate program personnel;	(X)	( )
(b) individual with developmental disabilities;	(X)	( )
(c) legal representative of individuals with developmental disabilities (where appropriate).	(X)	( )
3. Is the plan jointly signed by the following individuals:		
(a) the individual with developmental disabilities or his/her representative (where appropriate);	(X)	( )
(b) responsible program representative.	(X)	( )
4. Does the plan contain long-term habilitation goals?	(X)	( )
5. Does the plan contain intermediate habilitation objectives?	(X)	( )
6. Are the intermediate habilitation objectives expressed in terms which are measurable?	(X)	( )
7. Does the plan contain a description of how the objectives are to be achieved?	(X)	( )
8. Does the plan contain an evaluation procedure to determine if the goals and objectives were achieved?	(X)	( )
9. Does the plan contain a schedule for the evaluation procedure?	(X)	( )
10. Does the plan contain the name of the person responsible for the coordination of the program?	(X)	( )
11. Does the plan describe the specific habilitation service to be provided?	(X)	( )
12. Does the plan identify the agency(ies) which is (are) to deliver the service(s)?	(X)	( )
13. Does the plan identify the personnel who is (are) to provide the service?	(X)	( )
14. Does the plan describe the guidelines of the personnel who is (are) to provide the service?	( )	(X) **
15. Does the plan identify the specific date of initiation of each service?	(X)	( )
16. Does the plan specify the duration of each service?	(X)	( )
17. Does the plan specify the role and objective of all parties to the implementation of the plan?	(X)	( )
18. Does the plan require an annual review of the plan involving all individuals who originally created the plan?	(X)	( )

\*\* The guidelines are contained in the State Plan, not in each Individual Service Plan.



APPENDIX A





## Sub-Chapter 7

## Certification of Professional Persons

46.8.701 GENERAL (1) The department of social and rehabilitation services and the department of institutions shall jointly certify developmental disabilities professional persons and mental health professional persons.

(2) Definitions used for certification of professional persons in the areas of mental health and developmental disabilities are:

(a) "SRS means the department of social and rehabilitation services.

(b) "Institutions" means the department of institutions.

(c) "Mental health professional person" is a person

trained in the field of mental health and certified by SRS and institutions.

(d) "Developmental disabilities professional person" is a person trained in the field of developmental disabilities and certified by SRS and institutions.

(e) "Certification committee" means the committee with delegated authority to certify mental health professional persons and developmental disabilities professional persons.

(f) "Applicant" means a person seeking certification as a professional person.

(g) "Accredited program" means a program recognized and accredited by national accrediting agencies for academic and professional preparation programs.

(h) "Year of experience" means one year of full-time employment following receipt of the requisite minimum academic credential, or as otherwise provided for herein.

(3) Professional persons shall be certified for the following purposes:

(a) to recommend to the district court the most appropriate habilitation plan or treatment plan for an individual who is or may be found to be developmentally disabled or mentally ill based upon his evaluation of the individual when a commitment to a residential facility is being sought for that individual; and

(b) to be responsible for assuming the development and implementation of an assigned resident's individual habilitation plan or treatment plan when employed within a residential facility for that purpose as specified in Section 53-20-148 MCA.

(4) These rules shall not supercede or replace any rules or laws regarding the licensure of any professional provided for by law or other rules. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

46.8.702 CERTIFICATION COMMITTEE (1) The certification committee shall:

(a) review all applications requesting certification as professional persons;

(b) certify applicants as professional persons in accord with these rules; and

(c) perform other duties set forth by these rules or assigned to the certification committee by the directors of SRS and institutions.

(2) The certification committee shall be composed of the following membership:

(a) a person appointed by the governor who shall serve as chairperson of the certification committee; and

(b) the directors of SRS and institutions shall each appoint two persons representative of professionals eligible for certification.

(3) Members of the certification committee shall serve at the convenience of the appointing director. Meetings of the certification committee shall be called by the chairperson.

(4) The certification process as a professional person shall include:

(a) submission of application forms by applicant;

(b) a review within ninety days by certification committee of completed application forms to determine qualification of applicant for certification;

(c) an issuance of provisional or permanent certification by the certification committee or denial of the application;

(d) a notification of the disposition to the applicant within 30 days of the disposition of the application;

(e) permanent certifications are subject to periodic review. Provisional certification can be renewed by the regular application process set out in this rule. The certification committee may issue provisional certification that limits the professional person to providing specific services or limits the conditions under which the professional person can provide services, or the time period such certification shall be effective, or any combination thereof; and

(f) the certification committee may revoke certification by notifying the certified professional person in writing of the reasons for revocation at least 10 days prior to the effective date of revocation. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

46.8.703 RIGHT TO APPEAL (1) Any action of the certification committee concerning certification denial or revocation may be appealed to the directors of SRS and institutions. If the aggrieved party is not satisfied with the action of the directors, he may request to have his grievance heard by a professional persons certification grievance committee. The professional persons certification grievance committee shall be composed of four members who will be representative of professional groups, with two members appointed by the director of SRS and two members appointed by the director of institutions. All findings and actions of the professional persons certification grievance committee shall be binding on the certification committee.

(2) The notice of appeal shall be directed to the director of SRS or institutions.

(3) The appeal shall be in writing setting forth the nature of the grievance and arguments supporting the grievance and actions desired. The appealing party may also present oral argument before the grievance committee.

(4) All parties to the appeal shall be notified in

writing ten days prior to the hearing of the grievance committee. The written notice shall contain as a minimum, the date, day, time and location of the hearing.

(5) The guidelines for conducting the hearing shall be established by the grievance committee.

(6) If any party to the appeal is dissatisfied with the decision of the grievance committee, he may appeal to the appropriate district court of jurisdiction. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

46.8.704 CERTIFICATION OF PROFESSIONAL PERSONS, QUALIFICATIONS (1) Mental health professionals:

(a) Applicants possessing a license from the Montana department of professional and occupational licensing, board of psychologists, as a licensed psychologist, shall be eligible for certification as a professional person. Evidence of appropriate experience may be required at the discretion of the committee. For psychologists without such a license, the applicants shall possess a master's degree in psychology from an accredited program. Academic training shall be in a clinical field of psychology that directly relates to psychopathology. Applicants in the field of psychology shall have at least one year of experience in delivering professional services to clients in a mental health setting.

(b) In the field of guidance and counseling, applicants shall possess a master's degree in guidance and counseling from an accredited program and shall have at least one year of experience in delivering services to clients in a mental health setting.

(c) In the field of nursing, an applicant shall be a registered nurse, licensed under Montana law, preferably with a bachelor's degree in nursing and must have at least three years of nursing experience in providing services to clients in a mental health setting.

(d) In the field of social work, applicants shall possess a master's degree from an accredited program that provides training in the treatment of mental disorders and shall have at least one year of experience in delivering professional services to clients in a mental health setting. Membership in academy of certified social workers may be substituted for above education and experience.



(2) Developmental disability professionals:

(a) Applicants possessing a license from the Montana department of professional and occupational licensing, board of psychologists, as a licensed psychologist shall be eligible for certification as a professional person. Evidence of appropriate experience may be requested at the discretion of the committee. For psychologists without a license, applicants shall possess the following combination of experience and education:

(i) a doctoral degree from an accredited program and evidence of appropriate experience;

(ii) a master's degree with one year of experience in a developmental disability program setting; and

(iii) a bachelor's degree with three years of experience under the direct supervision of a professional person or a person eligible for certification.

(b) Applicants possessing a membership in the academy of certified social workers shall be eligible for certification as a professional person. Evidence of appropriate experience may be requested at the discretion of the committee. Applicants without an ACSW membership shall possess the following combination of experience and education:

(i) a master's degree with one year of experience in a developmental disability setting; and

(ii) a bachelor's degree with three years of experience under the direct supervision of a professional person eligible for certification.

(c) In the field of special education, applicants shall possess the following combination of experience and education:

(i) a doctoral degree from an accredited program and evidence of appropriate experience;

(ii) a master's degree from an accredited program with one year of experience in a developmental disability program setting; and

(iii) a bachelor's degree with three years of experience under the direct supervision of a professional person or a person eligible for certification.

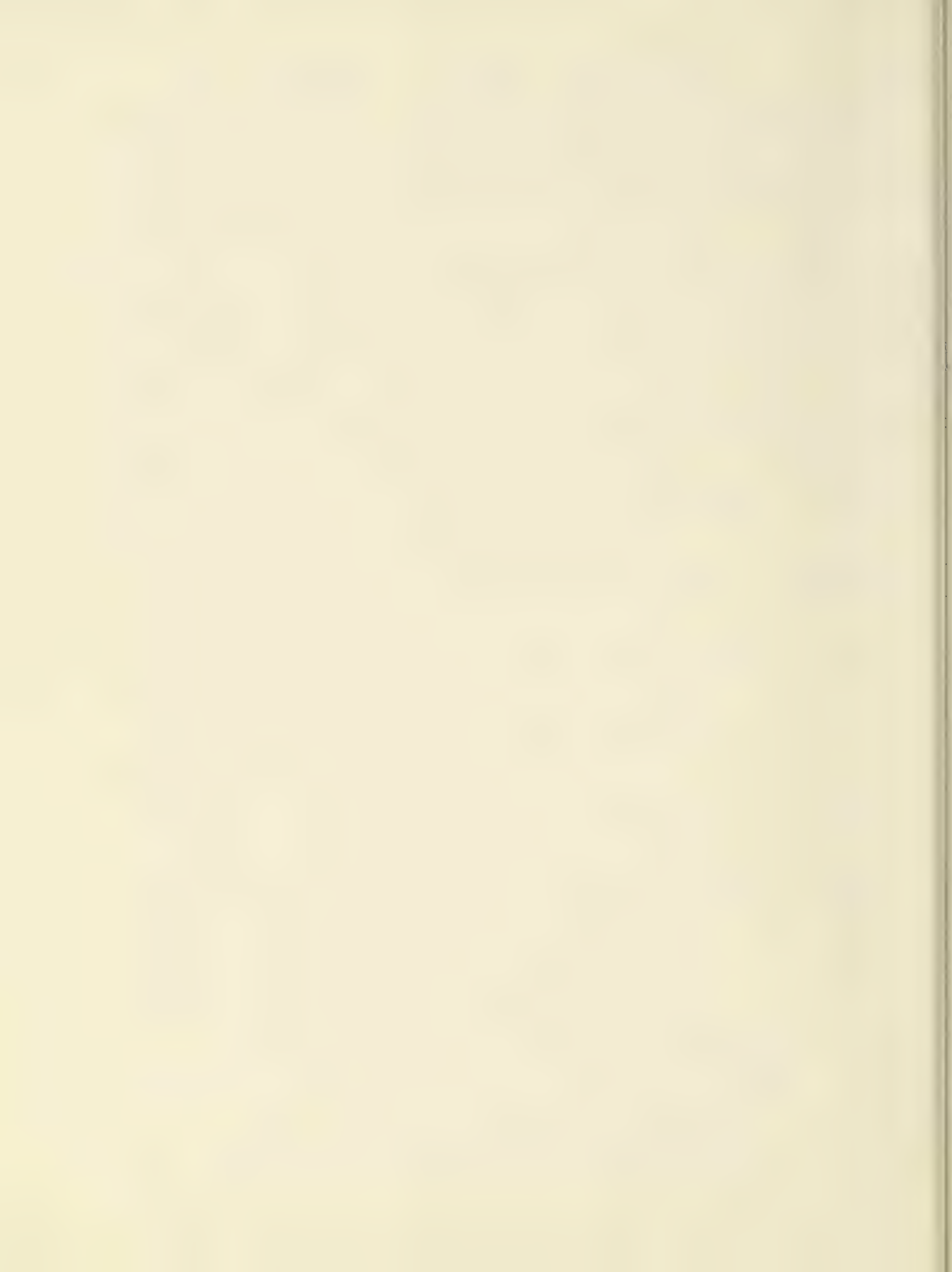
(d) In the fields of rehabilitation, physical therapy and occupational therapy, an applicant must have a bachelor's degree and at least three years of experience under the direct supervision of a professional person and involved in the planning and development of habilitation plans. Applicants must also provide as a part of their application a description of their expected duties and responsibilities as a developmental disabilities professional and a statement of need for certification from their supervisor.

(3) The certification committee may substitute experience for educational qualifications as determined by the committee to be appropriate or provided for within these regulations.

(4) The certification committee retains the right to determine the appropriateness of any experience; i.e., training, workshops, etc., for certification purposes. (History: Sec. 53-1-203 MCA; IMP, Sec. 53-20-102(7)(b) MCA; NEW, Eff. 6/7/76.)

APPENDIX B





MONTANA ADMINISTRATIVE CODE

48-2.18(34)-S18520 SUPERINTENDENT OF  
PUBLIC INSTRUCTION

Qualifications of Personnel

48-2.18(34)-S18520 SPECIAL EDUCATION TEACHERS. (1) Any teacher providing instruction in special education must be endorsed in special education regardless of time assigned to the special education program. During the time assigned to the special education program, the teacher may not be assigned to work with regular students.

(2) A special education teacher must be certified with an endorsement in special education. Special education endorsement is granted upon completion of a program approved by an accredited college or university.

(3) Provisional approval, until July 1, 1978, to teach special education may be granted by the Superintendent of Public Instruction to an individual who has a valid teaching certificate and at least 15 quarter hours in special education and is on a planned program with an accredited college or university to complete that institution's approved major or minor in special education.

(4) A teacher of the hearing impaired will not be approved for funding if the teacher only has provisional approval for a special education endorsement. The teacher's training must be in the area of hearing impaired through an approved program with an accredited college or university. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18530 TEACHERS OF HOMEBOUND AND/OR HOSPITALIZED STUDENTS. (1) A Teacher of homebound and/or hospitalized students need only hold a valid teaching certificate. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18540 SPEECH PATHOLOGISTS AND AUDIOLOGISTS.

(1) Except as provided in subsection (2), all public school personnel employed as speech pathologists and audiologists must have their license number on file with the Office of Public Instruction, Special Education Unit. Supervision shall be in accordance with the provisions of the individual's license.

(2) If a licensed speech pathologist is not available, the Superintendent of Public Instruction may approve the employment of school personnel as speech pathology technicians to deliver speech therapy services if the following conditions are met.

(a) The speech pathology technician shall have:

(i) a bachelor's degree in speech pathology verified by official transcripts,

(ii) 175 supervised clock hours in speech pathology or equivalent training and experience.

(b) The school seeking to employ a speech pathology technician must annually document its inability, after a comprehensive recruitment effort, to employ a licensed speech pathologist. The documentation shall include:

(i) copies of correspondence with educational institutions which offer graduate level training in speech pathology.

(ii) evidence of advertising in appropriate professional journals and recruitment through professional associations.

(3) Speech pathology technicians will be supervised by a licensed speech pathologist and there will be a minimum of four documented supervisory contacts per month between the pathologist and the technician. Additional direct supervision of the speech pathology technician will be determined by the licensed speech pathologist. It is generally recommended that there be a minimum of four documented on-site supervisory contacts per month.

(4) The speech pathologist and the speech technician shall develop the technician's program. The school district shall be responsible for assuring implementation of the program.

(5) The supervising speech pathologist and speech pathology technician shall comply with regulations promulgated by the Board of Speech Pathology and Audiology, and their interactions shall be governed by rule ARM 40-3.101(6)-S10120.

48-2.18(34)-S18550 SCHOOL PSYCHOLOGISTS. (1) The Superintendent of Public Instruction will approve persons to administer, score and interpret individual tests of learning aptitude (I.Q.) insofar as these persons present an acceptable transcript of university or college courses adhering to the criteria set forth below:

(a) Master's degree or fifth year in the pupil personnel services area that include the work set out below.

(i) Twenty-one quarter hour credits of undergraduate and graduate course work in the area of psychological foundations. These courses of which not more than 12 hours may be undergraduate, should include but are not restricted to

- (aa) general psychology
- (ab) educational psychology ,
- (ac) developmental psychology
- (ad) social psychology
- (ae) learning
- (af) physiological psychology
- (ag) personality
- (ah) abnormal psychology
- (ai) statistics
- (aj) research methods

(ii) Twenty-one quarter hour credits, of which not more than 12 hours may be undergraduate, in the area of psychological methods and techniques, including but not restricted to

- (aa) individual intelligence testing (REQUIRED)
- (ab) group intelligence and achievement testing
- (ac) personality assessment
- (ad) educational evaluation measurement
- (ae) interviewing and counseling
- (af) behavior modification and precision teaching
- (ag) school psychology practicum (STRONGLY RECOMMENDED--  
6 hours or letter of endorsement required)

- (ah) mental hygiene

(iii) Seventeen quarter hour credits, of which no more than 12 hours may be undergraduate, in the area of educational foundations and school organization and programs, including but not restricted to

- (aa) history of education
- (ab) social foundation of education
- (ac) educational philosophy
- (ad) remedial instruction--speech, arithmetic, reading
- (ae) school administration or supervision or curriculum
- (af) school practices and methods of teaching
- (ag) school guidance programs
- (ah) education programs for exceptional children--

organization, methods and materials

- (ai) mental retardation

(b) The college or university person responsible for the applicant's learning aptitude testing program must submit a letter of endorsement to the Superintendent of Public Instruction if the individual does not have a minimum of six quarter hours in a school psychology practicum. A person who has met all of the aforementioned requirements is authorized to perform psychological services for exceptional children with written approval from the Superintendent of Public Instruction.

(c) Persons satisfying these criteria will receive a letter of authority from the State Superintendent's office to administer, score and interpret individual tests of learning aptitude and to participate on child study teams as a school psychologist. Their authority to test is contingent upon confining their services to students enrolled in districts in which they are providing services. In no way is this authority to be construed as licensure of psychologists or an endorsement for the private practice of psychology or for contracting directly with parents to test a child or children. This authorization to administer, score and interpret individual tests will be valid for six years and renewed upon evidence of satisfactory performance. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

#### 48-2.18(34)-S18560 SUPERVISORS OF SPECIAL EDUCATION.

(1) Supervisors of special education must have a Class III administrators certificate with supervisors endorsement in special education. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)



48-2.18(34)-S18570 SOCIAL WORKERS. (1) A social worker employed to serve a special education program must have a minimum of a Master's of Social Work degree with verification to be submitted to the Superintendent of Public Instruction. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18580 COUNSELORS. (1) In order for a counselor to be funded by special education, the counselor must have a counselor's endorsement. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18590 NURSES. (1) A school nurse funded by special education must meet the requirements for a Public Health Nurse I as defined by the Montana Department of Health and Environmental Sciences and hold current licensure in the State of Montana. Verification of license must be on file with the Superintendent of Public Instruction. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18600 PHYSICAL THERAPISTS. (1) Physical therapists must have completed an American Medical Association/American Physical Therapy Association approved educational program, have the required clinical experience and hold a current physical therapy license issued by the Montana Board of Medical Examiners. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18610 OCCUPATIONAL THERAPISTS. (1) Occupational therapists must have completed an American Medical Association/American Occupational Therapy Association approved educational program, have required field work experience and be certified as a registered occupational therapist. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18620 VOCATIONAL EDUCATION INSTRUCTORS. (1) If a vocational education teacher is working in a special education program and does not have a special education endorsement, then that person must work under the supervision of certified special education personnel. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(34)-S18630 TEACHER AIDES. (1) There are no certification requirements for teacher aides. School districts may establish any requirement felt necessary for these positions. It should be recognized that aides are not trained teaching personnel and should be under the supervision of professional staff and not in the primary teaching role. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)



Caseload for Auxiliary and Supportive Personnel  
Serving Special Education Programs

48-2.18(38)-S18640 AUXILIARY PERSONNEL. (1) When specific curriculum area teacher (i.e., music, physical education) are assigned full-time to special education as a supplement to the special education program, the school district must obtain prior approval from the Superintendent of Public Instruction to consider that position as part of the special education program. The teacher must have a teaching certificate with an endorsement in the specific curricular area of instruction. In addition, the local school district should require that each teacher obtain specific skills which enable the teacher to deal effectively with handicapped children. These skills may be obtained through formal training or inservice training. Special education supervision must be provided to any auxiliary personnel.

(2) Auxiliary personnel will usually service at least ten to fifteen special education instructional units. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(38)-S18650 SPEECH PATHOLOGIST. (1) The caseload for a speech pathologist depends on the severity of

the handicapped students to be served. The suggested range is from 15-60 children. The caseload must be verified by a fully licensed speech pathologist (Rule 48-2.18(34)-S18540) before it will be approved by the Superintendent of Public Instruction. If the caseload is primarily hearing handicapped, then the caseload must be verified by a fully licensed audiologist and coordinated with the hearing impaired child study team.

(2) For budget purposes a full-time speech pathologist's minimum student base population is one pathologist per 1,000 students. In special circumstances, student base may not be appropriate. Exceptions may be negotiated with the Office of Public Instruction. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(38)-S18660 AUDIOLOGIST. (1) A full-time audiologist must serve a minimum school population base of approximately 10,000 regular students. In special circumstances, student base may not be appropriate. Exceptions may be negotiated with the Office of Public Instruction. Individual school districts that request funding of an audiologist must identify the service area of the audiologist to be covered. A population of less than 10,000 children will be considered for approval by the Superintendent of Public Instruction in consideration of the size of the area to be served. When an audiologist is working in a therapeutic capacity, that individual has the caseload recommended for a speech and hearing pathologist. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(38)-S18670 SCHOOL PSYCHOLOGIST. (1) A full-time school psychologist must serve a minimum population base of approximately 1,500 regular students. In special circumstances, student base may not be appropriate. Exceptions may be negotiated with the Office of Public Instruction. School districts that do not meet the minimum population base should consider cooperative programs between districts. Partial assignment of school psychologists to programs will be determined by prorating the minimum figure stated to the actual enrollment of the schools served. Approval to serve less than the minimal base may be considered by the Superintendent of Public Instruction when a request is made. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(38)-S18680 SUPERVISOR OF SPECIAL EDUCATION. (1) For budgeting approval, a full-time supervisor of special education must have a minimum of at least twelve full-time special education personnel or a regular student population of 3,000 regular students. In special circumstances, student base may not be appropriate. Exceptions may be negotiated with the Office of Public Instruction.

School districts are encouraged to establish cooperative special education programs under the direction of one supervisor of special education in order to meet minimum approval levels. Consideration should be given to include rural schools under this individual's supervision even though the rural school may not have a special education teacher.

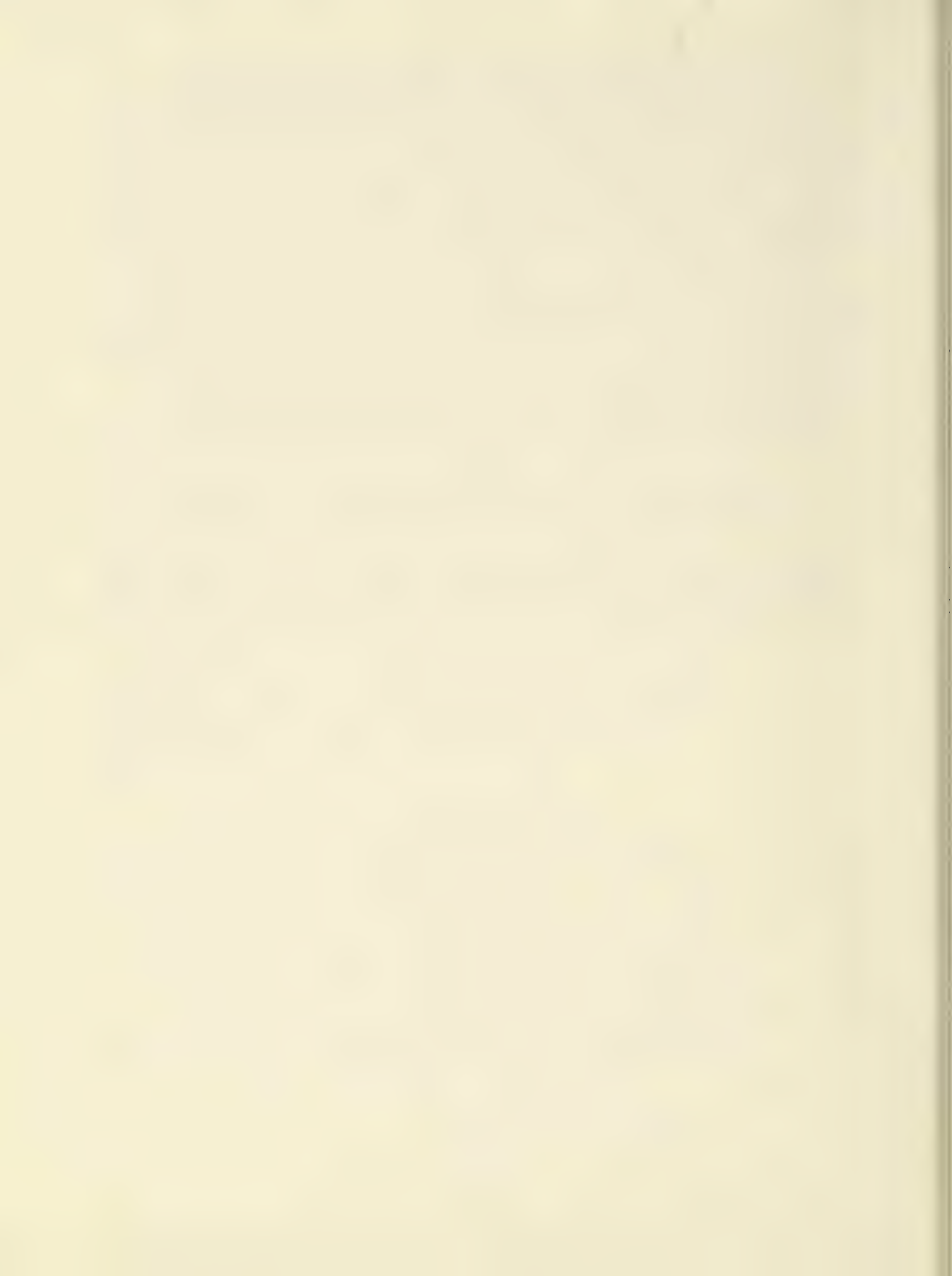
(2) For school districts that have special education personnel in excess of the minimum stated, additional supervisors may be added upon request to and approval of the Superintendent of Public Instruction. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(38)-S18690 SOCIAL WORKERS. (1) A full-time social worker must serve a minimum population base of approximately 3,000 regular students and/or have an assigned caseload of 25 to 60 families per year. In special circumstances, student base may not be appropriate. Exceptions may be negotiated with the Office of Public Instruction. The social workers shall serve children requiring special education through group or individual casework practice, consultation with school personnel and counseling with parents and students. The social worker shall be available to participate in child study teams when the need is indicated. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(38)-S18700 COUNSELOR. (1) A full-time counselor serving only special education must serve a minimum population base of approximately 3,000 regular students. In special circumstances, student base may not be appropriate. Exceptions may be negotiated with the Office of Public Instruction. The counselor must have a full-time assigned caseload of special education students requiring counseling on an instructional, behavioral or emotional adjustment related to the students' handicaps. The counselor should be available to participate in child study teams when the need is indicated.

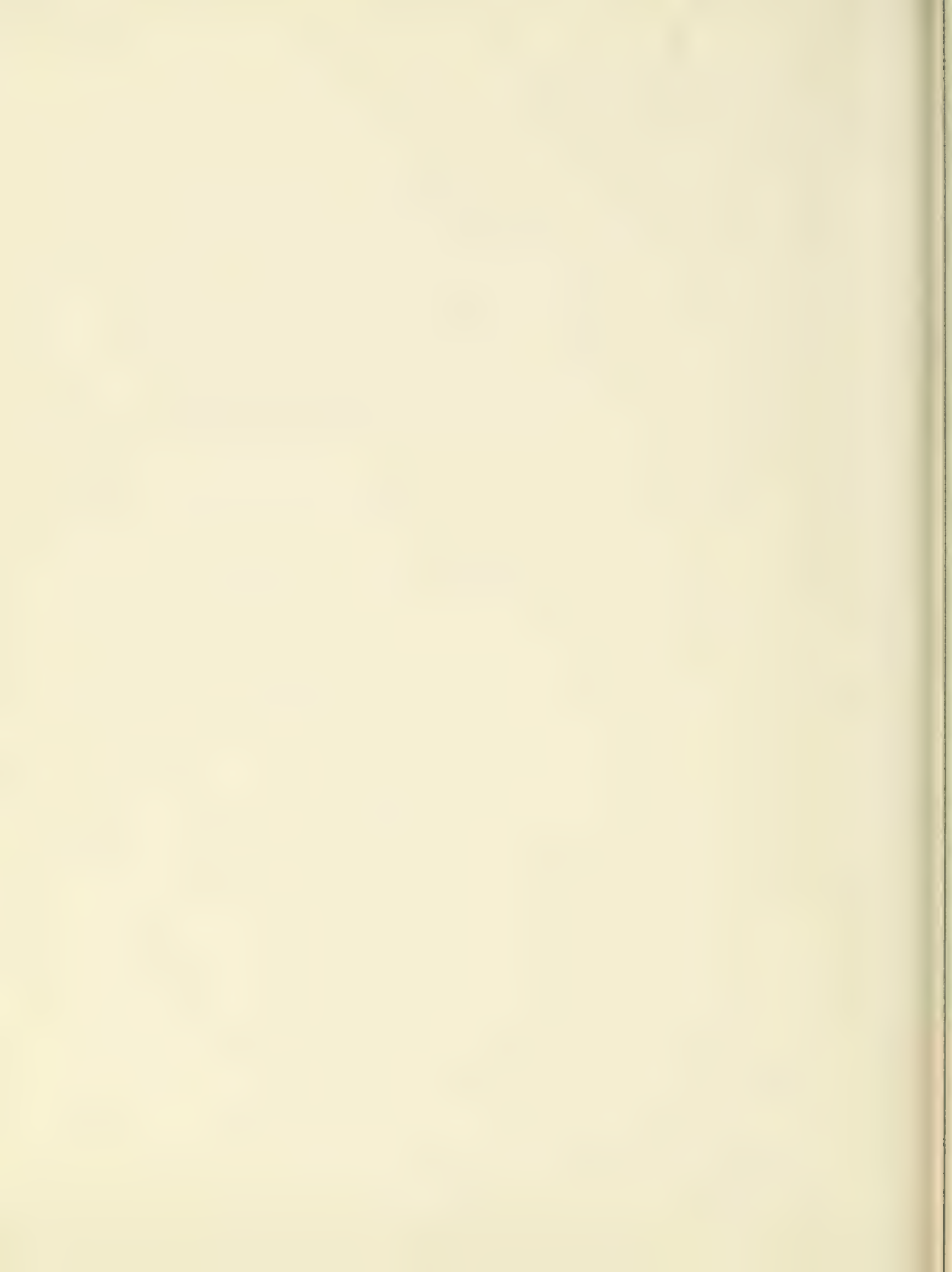
(2) If a school district budgets for and provides counseling services to handicapped students under special education, all of the students involved must also receive instructional special education service. Students needing only counseling are not eligible for special education counseling. These students are considered regular pupils and receive their total support from the regular program including counseling. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(38)-S18710 OTHER. (1) Before a school district employs full-time nurses, physical therapists or occupational therapists to serve special education programs, that district must justify the position to receive approval from the Superintendent of Public Instruction. (History: Sec. 75-7813.1, R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)



APPENDIX C





TEACHER CERTIFICATION STANDARDS

INTRODUCTION

- 1.1 Standards for certification of professionals in any field of service must reflect the practical limitations of that field at a given time as well as the continuing need for upgrading of professional competencies. The latter need relates especially to stimulation of a search for new knowledge and the useful application thereof. Standards must strike a proper balance. On the one hand pressures exist for the development of highly specialized personnel. On the other hand there is urgent need for professionals who are able to deal effectively with a wide variety of problems presented by a diverse handicapped population.
- 1.2 For teachers of the hearing impaired this implies a general competence to identify or diagnose educational problems arising from hearing loss in individuals of all ages from infancy to adulthood. Furthermore, the certified teacher must have certain specific competencies that will enable him or her, under supervision, to provide appropriate educational services in one or more special areas. Specification of these areas provides the essential basis for establishment of a system of professional certification. In essence, then, the certified teacher of the hearing impaired is expected to have a broad, general knowledge of the field with specialized abilities as a teacher in at least one area of concentration.

DEFINITIONS

- 2.1 Hearing Impaired. A hearing-impaired (deaf or hard of hearing) individual is a person who requires specialized education because of the kind and/or degree of hearing loss.
- 2.2 Basic Certification. The initial level of professional certification of teachers of the hearing impaired. Further defined in paragraphs 3.4 and 4.2-4.4.

- 2.3 Advanced Certification. The second and top level of professional certification of teachers of hearing impaired children. Further defined in Paragraph 3.4 and 4.3-4.4.
- 2.4 Conditional Basic Certification. A special one-year certificate issued to individuals wishing to renew a lapsed basic certificate.
- 2.5 Areas of Specialization. The areas of professional specialization for teachers of the hearing impaired are:
- 2.51 Preschool (Age 0 through 4)
  - 2.52 Elementary (Age 5 through 13)
  - 2.53 Secondary (Age 14 and up)
  - 2.54 Multiply Handicapped
  - 2.55 Special content and skill areas (e.g. art, vocational, etc.; separate certification standards to be developed)
- 2.6 Approved Teacher Training Center. An approved teacher training center is an accredited college or university whose program leading to basic or advanced certification of teachers of the hearing impaired has been approved by the Council on the Education of the Deaf.
- 2.7 Approved Practicum Center. An approved practicum center is a school offering a quality program for hearing impaired children, which program has been approved by the Council on Education of the Deaf as a locale for supervised observation and practice teaching. It shall offer opportunity for these experiences at one or more of the three following levels and shall have a population of deaf and/or hard of hearing children.
- 2.71 Preschool (0 through 4 years of age)
  - 2.72 Elementary (5 through 13 years of age)
  - 2.73 Secondary (14 years or age and up)
- 2.8 The practicum shall be supervised by coordinating and cooperating teachers holding advanced certification. The number of student teachers at any one time may not exceed the number of cooperating teachers holding such certification.

- 2.9 The program of the practicum shall include experience in:
- 2.91 Observation of classes of deaf children. Additional observation of hard of hearing children and normal children is desirable but optional.
  - 2.92 Diagnostic and tutorial services.
  - 2.93 Student teaching of deaf children. This experience shall ordinarily include practice at two levels (Paragraph 2.7) and, further, shall provide for significant full-day practice teaching experience in the area of the trainee's specialty.
  - 2.94 Participation in home-school-community relationships related to the hearing impaired.
  - 2.95 Participation in the applications of educational technology to the education of the hearing impaired.
- 2.10 Coordinating Teacher. One who organizes and administers the practicum program; must have advanced certification.
- 2.11 Cooperating Teacher. A teacher in the practicum center with advanced certification who has direct supervision of the trainee in his or her practicum work.

#### REQUIRED TRAINING

- 3.1 Pre-Professional Training. Prerequisite to specific training for teaching the hearing impaired, the candidate preparing for basic certification shall satisfactorily complete 18 semester (or 27 quarter) credit hours in the study of the following subjects:
- 3.11 Education
  - 3.12 Educational Psychology
  - 3.13 Educational Sociology
- 3.2 These requirements may be met prior to admission to the core training program or may be taken concurrently therewith but not in lieu of any part thereof.

3.3 Professional Training. Although it is recognized that competence is the ultimate measure of the teacher's qualifications, lack of specific standards of competency and lack of any general examination or other method for uniformly applying such standards necessitates use of the credit hour as the measure of training. A summary of the training requirements for Basic and Advanced certification are the following (further defined in Paragraphs 3.5 through 4.4.)

3.4 AREA OF PREP.

SEMESTER/CREDIT HRS. REQUIRED FOR CERT.

	For Basic Certification (Core)	Additional for Advanced Certification (Specialization)	Total
3.41 Psychology and Sociology	4	2	6
3.42 Communication	10	6	16
3.43 Curriculum	10	6	16
3.44 Practicum	6	2	8
3.45 Physiology, Audi- ology & Acoustics	4	4	8
TOTAL	34	20	54

Psychology and Sociology

3.5 Psychological and Sociological Factors in Deafness (6 semester hours).

3.51 CORE. (4 semester hours) The candidate shall, through study and direct experience, acquire knowledge of the implications of deafness for psychological and sociological development and adaptation.

3.52 SPECIALIZATION. (Additional 2 semester hours). For advanced certification, the teachers must submit evidence of further study and experience related to the specific psychological and sociological needs and behavior appropriate to the age of the pupil in the teacher's area of specialization.



## Communication

### 3.6 Competencies in Communication as Related to the Hearing Impaired (16 semester hours).

3.61 CORE. (10 semester hours) The candidate shall have basic knowledge in the fields of linguistics and cognition, and competence in the processes, techniques, and problems in communicating with and promoting communication skills in hearing-impaired individuals of all ages and all degrees of hearing loss.

SPECIALIZATION. (6 additional semester hours). For advanced certification, the teacher must submit evidence of further study and experience related to the specific communication needs and behavior appropriate to the pupils in the teacher's area of specialization. (see Paragraph 2.5)

## Curriculum

### 3.7 Curriculum for Education of Hearing-Impaired Children (16 semester hours)

3.71 CORE. (10 semester hours) The candidate must be knowledgeable about all phases of curriculum development in content subject areas and capable of creating a program which will stimulate cognitive development in hearing-impaired children.

3.72 SPECIALIZATION. (Additional 6 semester hours) For advanced certification, the teacher must submit evidence of further study and experience in interpreting and applying results of curriculum research in the area of specialization and related fields.

## Practicum

### 3.8 Practicum in the Teaching of the Hearing Impaired (8 semester hours)

- 3.81 CORE. (6 semester hours). The candidate shall submit evidence of having satisfactorily completed practicum requirements at an approved practicum center affording opportunity for practical application of theory and techniques through direct professional and social contact with hearing-impaired children and their families, and deaf adults in educational and community settings.
- 3.82 SPECIALIZATION. (additional 2 semester hours)  
For advanced certification, the candidate shall submit evidence of additional supervised teaching in the area of specialization at an approved institution. This requirement may be met by submission of evidence of one academic year of successful teaching under supervision in the area of specialization at an approved institution.

## Certification

- 4.1 Two types of certificates for teachers of the hearing impaired are provided. Each is renewable under conditions specified below, and neither is permanent.
- 4.2 Basic Certification. This certificate is issued to applicants who have successfully completed the study and practice of the core curriculum of professional training as set forth in Paragraph 3.4.
- 4.21 The basic certificate is good for a period of five years from date of issuance.
- 4.22 It may be renewed for a period of five years at the termination of the initial five-year period. If not renewed, the certificate is automatically lapsed.

- 4.23 A lapsed basic certificate may be renewed conditionally for one year upon request by the holder of the lapsed certificate.
- 4.24 At the end of one year from the date of issuance of the conditional certification:
  - 4.241 Failure to qualify for full reinstatement of the certificate will result automatically in permanent termination of the certificate.
  - 4.242 Full renewal of the certificate will be issued for an additional period of five years upon application and admission of:
    - 4.2421 Evidence of completion of 6 credit hours applicable toward advanced certification, plus....
    - 4.2422 ...evidence of completion of one year's successful teaching experience.
- 4.3 Advanced Certification. The Advanced Certificate is issued to teachers who have successfully completed the core curriculum for basic certification plus an additional program of specialized preparation in one of the areas of specialization (Paragraph 3.4)
- 4.4 The Advanced Certificate is good for a period of five years from date of issuance. The candidate for renewal of the Advanced Certificate must submit evidence of having met at least one of the following conditions:
  - 4.41 Successfully complete three semester hours of course work directly related to the candidate's area of specialization (Paragraphs 2.51-2.55) at an accredited institution.
  - 4.42 Taught a semester course in some aspect of special education in a college or university.

- 4.43 Participated in the program at a national, regional or state convention related to special education or did committee work for such.
- 4.44 Attended as a participant at an approved workshop or course at the national, regional, or state level.
- 4.45 Published in a professional journal.
- 4.5 Teachers with Class A and B Certification from the Conference of Executives of American Schools for the Deaf will automatically receive advanced certification under the newly inaugurated program.
- 4.51 Such teachers must meet renewal requirements as set forth in Paragraph 4.4 above.
- 4.6 The above certification standards apply to all academic teachers of the hearing impaired.

APPENDIX D





46-2.14(94)-S14950 STANDARDS FOR SPECIFIC TYPES OF PERSONNEL

(1) Medical diagnosis and medical treatment are provided handicapped individuals only by physicians licensed to practice medicine and surgery and otherwise qualified by training and experience to perform the specific services required. Persons providing physical restoration services will meet standards which insure services of high quality. It will be the policy of the State Division to allow the client free choice of physician for diagnostic and treatment services, wherever possible and desirable.

(2) The standards of personnel providing physical or occupational therapy are registry, or graduation from a school for the training of therapists generally accepted by the profession, and licensed by the State.

(3) The standards of qualification of personnel providing nursing services are registration, or eligibility for registration, as a graduate nurse; or registration, or eligibility for registration, as a practical nurse.

(4) Dental diagnosis and dental treatment are provided only by dentists who are licensed to practice dental surgery, and otherwise qualified by training and experience to perform the specific dental service required.

(5) The standards of personnel providing optometry service will be those licensed to practice optometry.

(6) The standards of personnel providing services as an osteopathic physician will be those licensed to practice medicine.

(7) Standards for the selection of prosthetists have been established. These standards are based on the professional standards established by the American Board for Certification of the Prosthetic and Orthopedic Appliance Industry, Inc. In the event there are not prosthetists available who meet such standards, the State Division will utilize the services of those prosthetists who are acceptable to other public and private agencies.

(8) Standards for the selection of speech and hearing therapists have been established. These standards are based on the professional standards as established by the American Speech and Hearing Association for the certification of clinical competence and/or Montana State License.

(9) The State Division will determine which of the services required are specialty services; and that services determined to be specialty services will be rendered only by physicians found by the State Division to be specialists qualified to perform the particular specialty service required. In providing specialty medical service, the Division will use medical specialists who hold certificates of the American



Medical Specialty Board, where such boards have been established, or physicians who have established eligibility to examination by such boards; or, when no physicians are available in one of these fields who meet either of the above standards, other qualified physicians, approved by the Medical Consultant are used.

(10) Standards for selection of psychologists have been established. These standards are based on professional standards. The Division will use only psychologists who are licensed to practice psychology in Montana or employed as a psychologist for an institution, academic institution, governmental agency or research laboratory providing these persons are performing the duties for which they were employed by these organizations.

(11) The State Division has established and will maintain standards for selection of training personnel who are qualified to conduct and carry out satisfactory training activities as relates to the specific training desired. (History: Section 71-2102, R.C.M. 1947; NEW, MAC Notice No. 46-2-111, Order MAC No. 46-2-59; Adp. 12/15/76; Eff. 1/3/77.)







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